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COLLECTED PAPERS 1955-1970, M. D. PARRISH, M.D. COLONEL MEDICAL--ETC(U)
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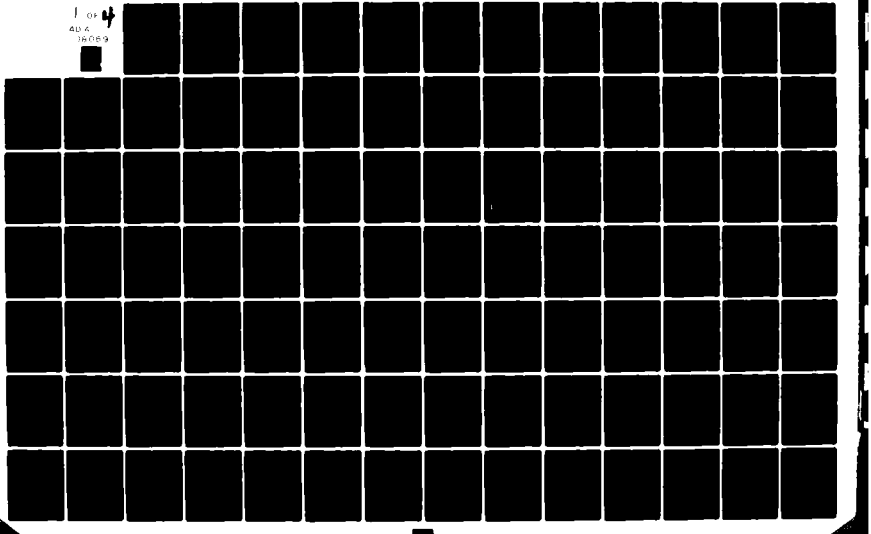

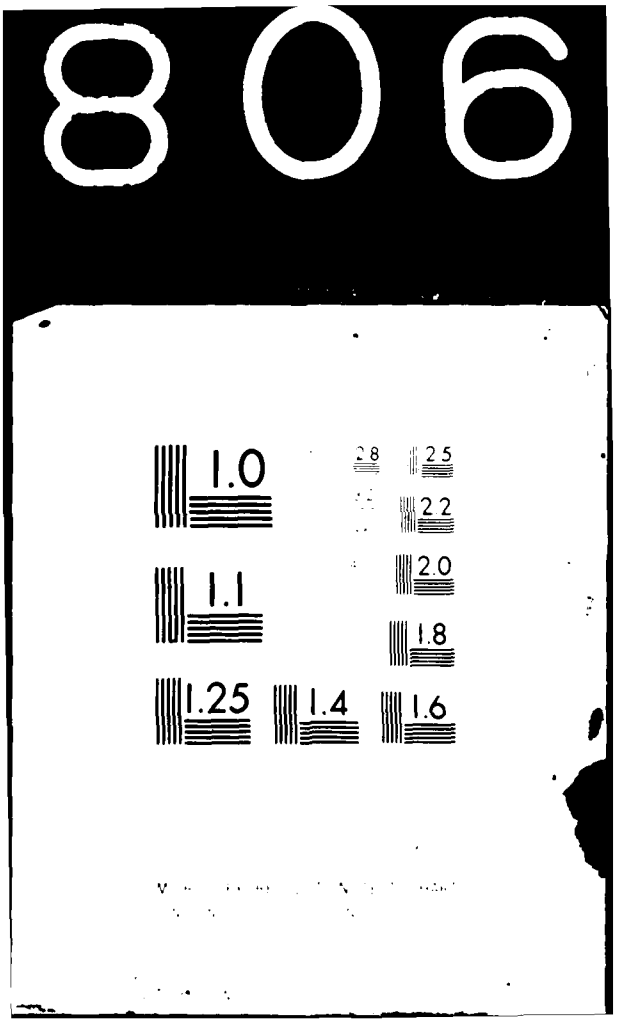
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COLLECTED PAPERS 1955-1970

M. D. PARRISH, M.D.

COLONEL MEDICAL CORPS US ARMY (RET)

EDITED BY

FRANKLIN DEL/JONES, M.D.
COLONEL, MEDICAL CORPS
PSYCHIATRY AND NEUROLOGY CONSULTANT
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HEADQUARTERS DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
WASHINGTON, D.C. 20310

ABSTRACT

Franklin D. Jones, MC
Psychiatry & Neurology consultant
Pentagon 2D520 DASG-PSC-P
Washington, DC 20310

Title: M.D. Parish, MD: Collected Papers 1955-1970

AUTHOR: Franklin D. Jones, MD, COL, MC (Editor)

Text: This is the first of companion volumes of the works of a senior career Army psychiatrist whose military career spanned three wars and during which he served in every major psychiatric role from trainee to Psychiatry and Neurology Consultant in Vietnam and in the Office of The Surgeon General of the Army. The other volume entitled M.D. Parris, MD: Collected Works 1970-1980 is available from the Defense Technical Information Center as Document Number ADA 102553. The current volume (1955-1970) has the following contents: (see attachment).

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M.D. PARRISH, M.D.
COLONEL MEDICAL CORPS US ARMY (RET)

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26. Group as Organism: Lecture No. 1 to Psychiatric Aides

    Roles in Group: Lecture No. 2 to Psychiatric Aides

    The Group's Influence Upon the Unconscious: Lecture No. 3 to Psychiatric Aides

    How to Make Patients Sicker: Lecture No. 4 to Psychiatric Aides

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27. Marathon Group Literature

28. The Problem of Being From Iowa

29. The Lone Innovator - 12 Oct 1973 (Not written by M. Parrish - but quoted by permission of the author

30. Kerygma and Myth - Thoughts After Reading the Book - 5 Jul 1973

31. Chaplains Sensitivity Group - Walter Reed General Hospital - 1966

32. Annotated Bibliography for Community Mental Health Theory - revised 12 Jan 1978

33. Teaching Writing (May, 1967) - 12 Jul 1974

34. A Marathon Group - April 29-30 1967

35. A Year's Adventure at WRAIR - Psychiatry

36. MHCD Morale - Key to Effective Community Mental Health Work

37. The Community Mental Health Consultant and His Education - Jun 1967

38. Mental Hygiene Consultation Division - 25 Aug 1976

39. Informal Principles Underlying Management of Mental Hygiene Problems - 26 Jul 1974

40. Letter to Dr Nathan S. Kline - 16 Oct 1967

41. The Use of the Local Community's Own Energy and Intelligence in its Mental Health Programs - 18 Apr 1972

42. Taste: A Necessary Ingredient in the Genesis of Civilization? - Aug 1967

43. The Social Nervous System - Jan/Feb 1968

44. Man-Team-Environment Systems in Vietnam - revised 13 Apr 1973

45. The Nomad and the Cultivator (Comments on "The Frontier in History", Page 469 in Studies in Frontier History by Owen Lattimore - 3 Dec 1975

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46. The Megahospital During the TET Offensive - May/Jun 1965

47. The Coming Unitary Life - revised 1 May 1978

48. A Group-Psyche Model for Teachers of Community Psychiatry - 3 Aug 1968

49. The Changing Field of Army Psychiatry

50. Narration - Vietnam as a Surgical Center

51. Marathon Group Techniques and Theory - 14 Mar 1973

52. How the Community Consultant Deals With the Structure of His Social Systems

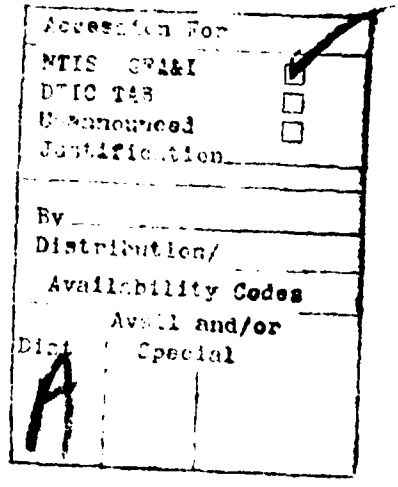
53. The Increasing Psychiatric Caseload vs Decreasing Staff

54. Army Mental Health Activities in Vietnam: 1965-1970 - Nov 1970

55. The Military and the Civilian Psychiatrist - United States and Swiss

56. Psychiatry in Combat Zones - 1970

57. Characteristics of Preventive Psychiatry Facilities - Washington 1970



M.D. Parrish, M.D.: An Appreciation

By

Franklin Del Jones, M.D., FAPA, COL MC

Psychiatry and Neurology Consultant

Office of The Surgeon General of the Army

Pentagon 2D520 DASG-PSC-F

Washington, DC 20310

Matthew Denwood Parrish was born in Washingon DC on 1 April 1918. He received a BA in English at the University of Virginia, Charlottesville, in 1939. During World War II he served 13 months in aerial combat in the Pacific as navigator and two years teaching navigation. After the war he attended medical school at George Washington University, receiving his MD in 1950. He then interned at Letterman Army Medical Center, San Francisco (1950-1951) followed by psychiatric residency at Walter Reed Army Medical Center, Washington, DC (1951-1954). He then successfully served as follows: Psychiatrist, US Army Far East Command (Japan and Korea) - 1954-1956; Chief, Mental Hygiene Consultation Service, Ft Belvoir, VA - 1956-1960; Assistant Chief, Psychiatry and Neurology Consultant to Army Surgeon General - 1960-1962; Chief, Psychiatry Service, US Army Hospital, Frankfurt, Germany - 1962 -65; Chief, Psychiatry Department, Walter Reed Army Institute of Research -1965-1967; Chief Psychiatry and Neurology Consultant to Army Surgeon General, 1968-1971 followed by retirement from the Army. Since 1972 Dr. Parrish has served in various positions in the Illinois Mental Health system and is currently Superintindent, Singer Mental Health Center - 1974-Present.

Those are the bareboned facts about one of US Army psychiatry's most colorful, charismatic and delightful members. Fleshing out this epistolary skelton would require many volumes and is beyond the scope of this narrative. Instead I hope to give a personal reminiscence of Matt to give a flavor of this mensch.

As is, I think, characteristic, I heard about Matt long before meeting him. While being introduced to concepts of group therapy and management of the psychiatric milieu as a first year psychiatric resident at Walter Reed Army Medical Center (WRAMC) in 1962, I had the good fortune to have a social worker, Curt Knighton, as mentor. Curt described Matt's use of music in group therapy. Guided imagery and similar concepts were at least a decade later in being recognized as a therapeutic use of music, yet, here was Matt pioneering in his understated way.

I continued to hear rumors about this strange man who was always coming up with new ideas or a different perspective on old ideas. Our paths did not cross, however, for Matt was serving in Germany during my residency; then, when he returned to the DC area, I had left for Vietnam by way of a few months in Hawaii. Finally on return from Vietnam and being assigned to The Surgeon General's Office, I became familiar with Matt's involvement with the research ward for treating sociopathic soldiers, a program which I was later to direct.

Matt visited Henderson Hospital, Sutton, England in 1965 and arranged to "live - in" for a week with the antisocial personalities being treated in that therapeutic community initially established by Maxwell Jones. He characterized the experience as "fraught...with adventurous and stressful learning...".

This is Matt's approach to life, in Helen Keller's phrase, "...a great adventure, or nothing". I recall one of Matt's early Army recruiting attempts. He enjoined young psychiatrists to enter the Army in order to go to Vietnam; for,

while, like most rational beings, he views war as a tragedy, it is also the great laboratory of human stress. So persuasive is Matt that a few actually did join.

In the ensuing years I had a number of opportunities to exchange ideas with Matt. While Matt might sometimes engage in apparently outrageous behavior (disrobing in a staid psychiatric meeting comes to mind as an example), his maneuvers were always couched in a way to bring fresh insights to a situation (such as the need to get down to essentials in the example).

Thus over the years Matt became a kind of role model for many of us, an inspiration to look beyond the surface, probe our own as well as our patients' humanity. Publishing some of his ideas, I hope, will allow others to share my appreciation of Matt.

Washington, DC - July 1981

Frank Jones, MD

September 1, 1980

CURRICULUM VITAE

Matthew D. Parrish

Born: Washington, D.C., April 1, 1918

Home Address: 1854 Telemark Drive, Rockford, Illinois 61108

Office Address: H. Douglas Singer Mental Health Center
4402 North Main Street, Rockford, Illinois 61103

Basic Education	Degree	Graduated
Univ. of Virginia, Charlottesville, Va.	BA (English)	June, 1939
George Washington Univ., Washington D.C.	MD	May, 1950
Letterman Gen. Hospital, San Francisco, Calif.	1 yr. Rotating Internship	June, 1951
Walter Reed Gen. Hospital, Washington, D.C.	3 yrs. Psychiatric Residency	July, 1954

Continuing Professional Education

1. Washington School of Psychiatry, Washington, D.C.: one to three night school courses per year during 1951-1954 and 1956-1959 including interpersonal psychiatry, psychoanalytic theory, anthropology, psychotherapy technique, history of psychoanalysis, basic psychiatric literature.

2. Personal psychoanalysis approximately 450 hours 1957-1961 with Dr. Herman A. Meyersburg, Training Analyst for Washington Psychoanalytic Institute.

3. Walter Reed Army Medical Center, Washington, D.C.: Seminar in psychiatric literature October 1958 to May 1959 with Dr. Kenneth Artiss. Also, a four week full time, live-in course in Experimental Basis of Modern Psychiatry, March, 1959.

4. Tavistock Institute of Human Relations, 3 Devonshire Street, London W1: a two week, full time live-in course in human relations (group dynamics) in August, 1964. I repeated this course at Mt. Holyoke College, Mass., July, 1966.

5. (a) Therapeutic Community, Dingleton Hospital, Melrose, Scotland: A one week, live-in participant living-learning experience with Dr. Maxwell Jones, March, 1965.

   (b) Therapeutic Community, Henderson Hospital, Sutton, Surrey, England: A similar one week experience at Dr. Jones' original therapeutic community for character and behavior problems, August, 1965.

6. Associated Faculties of Psychiatry (a consortium of fourteen university and governmental faculties), 1810 New Hampshire Avenue, N.W., Washington, D.C.: a two year night course and practicum in Community Psychiatry. Graduated in June, 1967. This course included social and community organization theory, relations with Federal, State and Private Foundation support. Participation in the development of three bills in State legislature.

Curriculum Vitae
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Continuing Professional Education continued:

7. Brief seminars and teaching conferences (two to five days duration): Four to six per year since November, 1967. Category-I CME always over 130 hours per year.

8. Seminar on Community Mental Health Principles in Action, Harvard Medical School, May 23-25, 1973.

9. Colloquium in General Psychiatry and Applications to Human Services Design, Northwestern University, January-May, 1973.

10. Authority, Leadership & Organization, Tavistock Institute of Human Relations, 3 Devonshire Street, London W1: April 2-16, 1975, (a two week, full time course).

11. Preparation Course for Psychiatry Boards, Yale University, New Haven, February 14-18, 1977.

12. Introduction to Automatic Data Processing for Health Specialists, U.S. Dept. HEW, Federal Building, San Francisco, February 26-March 1, 1979.

Employment Record

October 1974 -	Illinois State Dept. of Mental Health & Developmental Disabilities, H. Douglas Singer Mental Health Center	Superintendent of a 200 bed hospital. As a second duty, I continued to coordinate all staff mental health training as below.
February 1972 - December 1977	Illinois State Department of Mental Health & Developmental Disabilities	Director of Training (for about 22,000 State Mental Health employees, plus the administration of State grants and other support to universities and private training institutions).
January 1971 - January 1972	Self employed writer and consultant in behavioral sciences, working chiefly with Blackman's Development Center, Washington, D.C., and in short term projects with State of Illinois Department of Mental Health; Virginia Department of Vocational Rehabilitation; Walter Reed Army Institute of Research; Church of Jesus Christ of Latter Day Saints; Long Island University; Center for Development of Human Relations in the Planned City of Columbia, Md. In Washington, D.C.: Community Consultants, Inc.; Associated Faculties of Psychiatry.	
July 1968 - December 1970	Army Surgeon General's Office Washington, D.C. (retired December 31, 1970)	Colonel, Chief Consultant in Psychiatry and Neurolog

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Employment Record continued:

	This work required staff coordination on public or Army-wide policy in which psychiatry or neurology had a part--including assignment of all army psychiatrists worldwide; monitoring of all major neuropsychiatric operations; training and research; creatively writing into VIP speeches and publicly released articles any appropriate human relations information and policy; membership in Department of Army committees concerned with morale and discipline, public health, environmental influences; review of cases alleging medical injustice or problems of mental competence; consultation and teaching to other departments, including Public Health Service, NIHM, Peace Corps, U.S. Navy. Social Work and Psychology functions were also under my supervision. I led training workshops in human relations, sensitivity encounter groups, and interdisciplinary management networks for both governmental and civilian agencies.	
July 1967 - July 1968	U.S. Army, Vietnam Office of the Surgeon	Colonel, Chief Consultant in Psychiatry for the Theater of War. Additional duty Editor-in-Chief, USARV Medical Bulletin.
September 1965	Walter Reed Army Institute of Research. Projects under my supervision included operant conditioning with behavior disorders, psycholinguistics, social psychiatry, neurology, transcultural medical education.	Lt. Col., Asst. Chief, and then Chief, Department of Psychiatry.
September 1962 - September 1965	U.S. Army Hospital, Frankfurt am Main, Germany	Lt. Col., Asst. Chief, and then Chief, Department of Psychiatry and Neurology
May 1960 - August 1962	U.S. Army, The Surgeon General's Office, Washington, D.C.	Lt. Col., Asst. Chief, and later, Chief Consultant Psychiatry and Neurology
July 1956 - May 1960	U.S. Army, Ft. Belvoir, Va.	Major, Chief, Mental Hygiene Service
July 1954 - July 1956	U.S. Army Far East: Japan and Korea	Capt., Psychiatrist
July 1951 - July 1964	Walter Reed Hospital	Psychiatric Resident

Cirriculum Vitae
Matthew D. Parrish

Employment Record continued:

June 1950 - July 1951	Letterman General Hospital	1st. Lt., Interne
September 1946 - May 1950	George Washington University	Medical Student
February 1946 - September 1946	George Washington University	Pre-med courses (one year undergraduate credit).
November 1945 - February 1946	Vacation	
May 1942 - November 1945	Army Air Corps	Navigator, Lt., Capt. (Combat Aircrew)
	This work included 13 months in aerial combat--Aleutian Islands Campaign and Air Offensive Japan--and two years of teaching navigation. The last year was spent as head of a navigation ground school for B-29 crews, Clovis, New Mexico	
August 1941 - May 1942	Air Corps Training Center Maxwell Field, Alabama and Turner Field, Georgia	Aviation Cadet
May 1941 - August 1941	116th Inf., Ft. Meade, Md.	Private (Basic Training)
October 1939 - May 1941	U.S. Government Printing Office, Washington, D.C.	Book Bindery Worker

Avocational

Linguistics: As an undergraduate, I studied linguistics under Professor Archibald Hill, University of Virginia 1938-39. I took a semester in linguistics under Dr. Edith Trager at Walter Reed Army Institute of Research, 1960-1961. I studied the German language in night school at the Volksbildungsheim, Frankfurt, Germany, 1962-65. Using group therapy principles I directed an interactional language learning group in German at the U.S. Army Hospital, Frankfurt, Germany, 1962-63, employing five German language teachers for about nine months.

In order to understand cultural shock and linguistic problems, I spent sixteen days in the mountains of Greece, speaking only Greek, in October 1963. I spent a similar fourteen days in the Japanese countryside in 1956 and again six days in 1968 speaking only Japanese.

Painting and Drawing: One-term courses in portrait and figure painting at YWCA, Washington, D.C., 1954; at Special Services School, U.S. Army, Yokohama, 1955; at Silver Spring Art Studio, Silver Spring, Md., 1960; at Volksbil-

Curriculum Vitae
Matthew D. Parrish

Avocational continued:

dungsheim, Frankfurt, Germany, 1964 (class was conducted in German). I exhibited my paintings at Japanese artists exhibition, Yokohama, 1955.

Music: Studied cello under Mr. Ben Levenson, Silver Spring, Md., 1960-61. From earlier training, I remain an amateur player of flute, clarinet, viola da gamba.

Photography: I developed and enlarged photos since age 14, both macro and micro photography, about 100,000 prints and slides.

Astronomy: Observed and plotted stars since age 14. Invented a computer for use with the aerial sun compass in 1943. This made the sun compass convenient to use. Formerly, it was in disuse because it involved too much computation. In 1944, I devised a method of rapidly precomputing celestial fixes in flight.

Social: Married to Marilyn Kay Parrish, RN. Four children, only one still dependent.

Religious preference: Episcopal

Professional Societies

Fellow, American Psychiatric Association (Member 1954- , Fellow 1970 -)
Member, Washington Psychiatric Society, Washington, D.C. (1954 -)
Member, American Society of Group Psychotherapy and Psychodrama (1959 -)
Member, Associated Faculties of Psychiatry, 1610 N. Hamp Avenue, Washington, D.C. (1965 -)
Member, Inter University Seminar on Armed Forces and Society, University of Chicago, Department of Sociology (1967 -)
Member, Association of Military Surgeons, Washington, D.C. (1970 -)
Member, Association for Advancement of Science, Washington, D.C. (1970 -)
World Federation of Mental Health, University of British Columbia, Vancouver, B.C. (1977 -)
Society of Medical Consultants to U.S. Armed Forces, 153 W. 11th St. New York City, New York 10011 September 1979 -.

Teaching Appointments

Clinical Professor of Psychiatry, Abraham Lincoln School of Medicine, University of Illinois, Chicago, 1972 to 1976 at the University of Illinois Rockford School of Medicine to the present.

Professor of Social Work, Jane Addams School of Social Work, University of Illinois at Chicago Circle, Chicago, Illinois, April 1975 to June 1976

National Committees

Member, President's Committee on the Handicapped (May 1961 - September 1962)

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National Committees continued:

Assoc. Member, Committee on Governmental Agencies, Group for Advancement of Psychiatry (November 1968 - November 1970)
Member, Committee on Federal Government Health Agencies, American Psychiatric Association (December 1968 - October 1970)
Member, Manpower Commission, American Psychiatric Association (August 1970 - December 1971)
Committee on Mental Waivers of Immigrants, Atlanta, Georgia, April 10-11, 1972 (Represented Director, Department of Mental Health, Illinois)
National Conference on Technical Assistance and Support Systems for Education, Washington, D.C., May 28-30, 1974 (under U.S. Office of Education)
Jane Addams School of Social Work Advisory Committee for development of national continuing education program under auspices of the National Council on Social Work Education, October 1973 to June 1976
National Association of Mental Health Program Administrators Tri-State Planning Committee for Forensic Training, Region V, 1977

State Committees

Illinois State Advisory Committee for the Continuing Education Program in Community Mental Health, June 1973 to present
University of Illinois Advisory Committee on curriculum for degree of Bachelor of Social Work - Jane Addams School of Social Work, University of Illinois, Chicago, November 1972 to January 1974
Nursing Advisory Committee of Department of Registration and Education (to examine Illinois Nursing Education Act) August 1973 to July 1974
Illinois Implementation Commission on Nursing (of Illinois Nurses Commission, Chicago) representing Department of Mental Health, May 1973 to June 1977
Illinois Mental Health Planning Board Committee on Professional Societies, April 1972 to January 1974
Chairman, Medical Records Committee, Ill. Department of Mental Health April 1978 -
Continuing Medical Education Committee for Rockford School of Medicine, September, 1975 to present
State Board of Education's Illinois Area Health Education System (AHES), September 1975 to June 1977
Advisory committee for medical technical education, Department of Vocational and Technical Education, Illinois Office of Education. May 1973 to May 1978

Certificates and Licenses (current)

Diplomate, National Board of Medical Examiners, 1953
Certified in Psychiatry, American Board of Psychiatry and Neurology, 1959
Licensed by written examination to practice medicine in California, 1951
Licensed by reciprocity to practice medicine in Virginia, 1966 and in the District of Columbia, 1970
Licensed by eminence to practice medicine in Illinois, December 1972

Consultation Work

From December 1969 to February 1972, I was consultant in psychiatry to Blackman's Development Center, 6406 Georgia Avenue, NW, Washington, D.C. 20012. This is primarily a group of drug abuse treatment and rehabilitation centers which, in 1979 worked with about 12,000 drug dependents in Washington alone. The overwhelming majority were heroin users. The group employs methadone to help in rehabilitation, but does not use it for indefinite maintenance of dependents. It concentrates on

Cirriculum Vitae
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Consultation Work continued:

getting dependents away from crime and welfare, and into productive work and education. Drug dependents, ex-drug dependents and ex-convicts maintain a brotherly support for each other. As yet, no comparable rehabilitative support has been developed by government. The group strengthens families and neighborhoods, and develops racial pride without violence. It does similar work in Atlanta, Ga., and Columbus, Ohio. As a staff member, I contributed to the general operational planning, provided contacts with other agencies, and advised on medical psychology and pedagogy.

As a consultant, I have worked mainly in developing programs for better human relations within and between organizations. I teach and help set up mental health programs serving all the people in a community. I am personally interested in promoting preventive and curative programs from the following points of view equally: individual psychodynamics, group dynamics, family dynamics, the psychology of social and industrial organizations, political dynamics and trans-cultural forces. Nevertheless, I find myself consulting and teaching mostly concerning concepts and practices relating to prevention and rehabilitation rather than cure, and to societies and organizations rather than individuals. This occurs simply because few psychiatrists are currently enthusiastic about such work.

Consultation work since 1972 includes:

Department of Professional and Applied Studies, Sangamon State University, Springfield, Illinois 1970-1977

Regional Mental Health Center, Kokomo, Indiana 1974-1977

Denver General Hospital, Department of Psychiatry 1973-1977

Division of Manpower and Training, New York City Department of Mental Health and Mental Retardation Service, April 1973

Consultant in history of Vietnam War, to Army Historical Unit, Ft. Ritchie, Maryland, May 1973 to present

References:

Dr. Ivan Pavkovic, Acting Director, Illinois Department of Mental Health and Developmental Disabilities, 160 North LaSalle Street, Chicago, Illinois 60601

Dr. David McK.Rioch Institute for Behavioral Research, 2429 Linden Lane, Silver Spring, Maryland 20906

Dr. Maxwell Jones, 5911 East Calle del Paisano, Phoenix, Arizona 65018

Dr. LeRoy P. Levitt, Vice President, Medical Services, Mt.Sinai Hospital, Chicago, Illinois 60608

Dr. Bertram Brown, 7818 Greentree Road, Bethesda, Maryland

Lt. General Charles Pixley, The Surgeon General, Department of the Army, Washington, D.C. 20314

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References continued:

Dr. George Phillips, Superintendent, Crownsville State Hospital, Crownsville, Maryland 20132

Dr. Robert deVito, Chairperson, Department of Psychiatry, Strich School of Medicine, Loyola University, Maywood, Illinois.

Dr. Lewis Kurke, Assistant Director, Behavioral Health Services, Arizona State Hospital, 2500 East Van Buren Street, Phoenix, Arizona 85008

Dr. Albert J. Glass, 7420 Westlake Terrace, Bethesda, Maryland 20034

Dr. Melvin Sabshin, Medical Director, American Psychiatric Association, 1700 - 18th Street, NW, Washington, D.C. 20009

Publications

PARRISH, M.D.: "Consultation Concepts in Military Mental Hygiene", Medical Bulletin U.S. Army Europe 21: 18-20, January 1964

PARRISH, M.D. and MORGAN, Ralph W.: "The Problem of Being from Iowa" Medical Bulletin U.S. Army Europe 22: 467-468, December 1965

PARRISH, M.D.: "The Social Nervous System", U.S. Army Vietnam Medical Bulletin, 40-7: 42-46, January 1968

PARRISH, M.D.: "The Megahospital during the Tet Offensive", U.S. Army Vietnam Medical Bulletin, 40-9: 78-72 May 1968

PARRISH, M.D.: "A Group Psyche Model for Teachers of Community Psychiatry", Psychiatry, 31: 205-212 August 1968

PARRISH, M.D.: "Vietnam as a Surgical Center", JAMA, 206: 2600-2601, December 9, 1968

COLBACH, Edward M. and PARRISH, M.D.: "Army Mental Health Activities in Vietnam 1965-1970", Bulletin of the Menninger Clinic, 34: 333-342, November, 1970

PARRISH, M.D.: "The Military and the Civilian Psychiatrist--U.S. and Swiss", Military Medicine, 136: 587, June 1971

PARRISH, M.D.: "A Veteran of Three Wars Looks at Psychiatry in the Military", Psychiatric Opinion, December 1972

PARRISH, M.D.: "An Eclectic View of Mental Health Training Goals", Journal of Research and Training, Vol. 1, No. 1, September 1973 (publication of Illinois Mental Health Institutes)

PARRISH, M.D.: "Let's Tell the Vet What Happened to Him", Paper delivered to Annual Convention of American Psychiatric Association, Dallas Texas, May 1972 (for American Association for Social Psychiatry)

Curriculum Vitae
Matthew D. Parrish

Publications continued:

PARRISH, M.D.: "Support Systems in Special Education" in Maynard C. Reynolds (ed) National Technical Assistance Systems in Special Education, University of Minnesota Press 1975, pp 173-182

As associate author with faculty members of Social Work Department, University of Illinois:

"The Illinois Laboratory: A design for Learning" in Deborah Miller (ed) Expanding the Boundaries: Continuing Education in the Community Mental Health System, NY 1980 Council on Social Work Education pp 30-43

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July 24, 1978

Annotated Bibliography

By: Matthew D. Parrish

1. The Use of Music in Group Therapy (Tokyo, 1955) Early in the course of group therapy five minutes of recorded music was played. The members revealed their feelings and free associations to the music, thus opening up to each other their emotional potential.

2. Reflections on Group Therapy (Ft. Belvoir) Patients usually enter groups as self-centered individuals and no real group organism is present. As time goes on the group itself develops a relationship with each member including the therapist. In this complex relationship especially useful therapy can proceed.

3. Techniques of Group Therapy for Socially Ambulatory Adult Patients (Ft. Belvoir, 1960) Suggested techniques for obtaining useful group therapeutic interaction--especially for anxious new therapists.

4. The Dying Patient in the Mental Health Service (Ft. Belvoir, 1960) Several months of out-patient experience with a patient who was dying of cancer. Emphasis was on group treatment both in the clinic and in the home. There was some tendency, in effect, for the therapist to die with the patient.

5. Proverbs - Their Use in Individual and Group Evaluation (Ft. Belvoir, 1960) Proverbs (multiple interpretation of the same proverb) are used to evaluate a patient's or a group's creativity and the degree to which a member succumbs to the group's style of thinking.

6. Comments on Man and Technics by Spengler (Walter Reed, 1960) Subordinate to Western Culture as a great organism in itself, are two groups of elitists: warriors and priests. They are usually driven by the love of work by greed or by their own artistic creativity to produce for the sake of production itself. The most talented of these persons knows the least of the happiness and the contentment of the masses. Theses elitists are being destroyed by (1) the organization of technics in such a way as to control history itself, and (2) the relinquishment of the elite creativity in the name of egalitarianism. A cowardly optimism is replacing the grand tragedy once enacted by the West's dominent minority. Soon the world will no longer belong to Western history.

7. Symposium on Group Psychotherapy, Extract (Walter Reed, 1961) Brief resume of the author's own development as a group therapist. How his personal history itself changes as he moves to a new group or as each group alters. The orientation here, of course, is the treatment of groups not the treatment of individuals in a group setting.

8. Leadership and Psychotherapy - Fred Fiedler's Concepts (Washington D.C. 1961) Fred's research showed two kinds of leaders: (1) those who perform no better in competition than they do in routine work. They put the dignity of individuals ahead of the mission of the group. (2) The competitive leaders who are unaffected by the anxiety of other people. They are poor therapists for individuals but they are effective leaders of the group mission. This second group of leaders sees its fellows as distinctly different from themselves as individuals.

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9. Disaster: Nova Scotia Coal Mine (Surgeon General's Office 1961) A large group (12 persons) depersonalized their activities--even their leaders--who were all formed from subgroup coalitions. Small groups (six persons) showed leadership by each person individually (democratically). Two types of leaders arose in certain stages of disaster. (1) Escape leaders attacked problems directly without much empathy nor concern for interpersonal issues. (2) Survival leaders were smooth communicators instead of direct actors and were sensitive to moods and needs of others

10. Disaster: Tornado in Worchester (Surgeon General's Office, 1961) The sequences of social and individual behavior in the disaster syndrome. Types of mental breakdown. Cornucopia Theory.

11. Community Psychiatry in Modern Warfare (Chicago, 1961) Sequences of behavior to be anticipated in massive disasters. Preparation for and management of such disasters.

12. Comments on MHCS Work (Surgeon General's Office, 1962) Methods and theory of consultation to social units and leaders. Various useful programs in the mental hygiene service including preventive activities.

13. Concepts Which Facilitate the Teaching and Practice of Community Psychiatry (Surgeon General's Office, 1962) The radical changes in psychiatry itself allow it to be effective as an aid to community mental health instead of to solely individual anxieties.

14. The Service Psychiatrist: Administrator or Physician (Surgeon General's Office, 1962) Management, education and therapy are combined in the military psychiatrist to provide the optimum service.

15. Labor and Psychiatry (Surgeon General's Office, 1962) Notes on Parker's the Casual Laborer. New sorts of education are needed in order to fit labor better into modern society. Great reforms are usually best effected by a small herd.

16. Dear Tom (Frankfurt, am Main, 2163) Retrospect from the year 2163.

17. Consultation Concepts in Military Mental Hygiene (Frankfurt, 1964) An outline of how mental health consultation is done and how it is not done.

18. Sixth International Congress of Psychotherapy (London, 1964) Evaluation of papers presented by mental health professionals of many nations and many opposing points of view--including papers by Tom Main, R. Laing, Jurgen Reusch, Jock Sutherland, J. L. Moreno, Ferdinad Knobloch, Al Stanton, Isabel Menzies, Mertens de Wilmars, Roger Shapiro, Manfred Lindner, Steven Fleck, Maxwell Jones, etc.

19. Some Concepts of Military Psychiatry (Oslo, 1964) Effective principles and attitudes in military psychiatry including psychiatry.

20. Medical Aspects of Leprosy (Frankfurt, 1964) A discussion with Dr. R. G. Cochrane concerning this illuminating disease which is so prevelent

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in the tropics.

21. The Therapeutic Community: A Visit to Henderson Hospital (Sutton, 1965) The violent adventures in a weeks' living-in arrangement at this hospital for sociopaths. This is probably the most effective treatment sociopaths have ever obtained in any hospital.

22. Group Therapy of an Entire Closed Ward (Frankfurt, 1965) All the patients and all the staff met in a single group seven days a week as a part of the therapeutic milieu. The methods and the effect of the group are discussed and five short lectures on theory are presented.

23. Marathon Group Literature (Frankfurt, 1965) A short annotated bibliography of rather classical literature pertaining to the underlying theory of longterm group meetings (30 hours or more per session).

24. The Problem of Being From Iowa (Frankfurt, 1965) A case study of consultation to a military unit as a social group rather than as a collection of individuals.

25. The Lone Innovator (Walter Reed, 1966) Extract from a letter from Dr. Tom Main revealing the distortions of thought which occur in innovative groups and in the conservative groups they face.

26. Thoughts on Kerygma and Myth (Silver Spring, 1966) The importance of Myth and history, romance and science, on the development of modern theology. The effect of faith can be just as powerful as the effect of technology.

27. Chaplain's Sensitivity Group (Walter Reed, 1966) Report of the group growth and the symbolic development of a group of military chaplains meeting for 12 sessions. The choiceless role-play by various members.

28. Annotated Bibliography for Community Mental Health Theory (Ft. G. G. Meade, 1966) Influential sociological masterpieces.

29. Teaching Writing (Washington, 1967) How editors and teachers can get writers to write better.

30. A Marathon Group (Oakton, 1967) A skeletonized explication of the various modes of emotional reaction and the various channels of communication which tend to show themselves in sequence during the thirty hours of a Marathon Group. These group tendencies are further elucidated in a later paper, Marathon Group Techniques and Theory.

31. A Year's Adventure at WRAIR - Psychiatry (Walter Reed, 1967) A brief summary of eight fields of psychiatric research in this institution: (1) A token economy ward for sociopaths revealed disharmony between expressed personal plans and actual behavior; (2) Political science research uncovered the ward's process of establishing an unspoken "constitution"; (3) Sociological study of labeling in small societies on a military post uncovered quite a different sort of peer interplay than what was ever revealed in interview; (4) Traditional objective mental health consult-

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ation sometimes gave way to consultative work which looked like tribal or family acceptances; (5) Percepts with many gutty non-verbal connotations retained association across sensory modalities much better than "quieter" percepts; (6) Correlative meanings of delusional concepts became more pleasant with time; (7) The long duration of certain social and combat stresses in Vietnam gave a different stress response pattern than that usually found in normal work and life; (8) In medical care and education Thai and American professionals developed a usefully different relationship than either developed with their own peers.

32. The Mental Health Facility's Morale (Walter Reed, 1967) The convergence of enthusiastic talents shows similar patterns in several different facilities.

33. Education of the Community Mental Health Consultant (Washington, 1967) Practical needs for certain skills in several different societies required polarized type of education.

34. Mental Hygiene Consultation Practice - A Manual (Walter Reed, 1967) Written in outline form like a regulation; this guide shows how service was usually carried out in practice, but not in openly discussed or written rules.

35. Informal Principles Underlying Management of Mental Health Problems (Long Binh, 1967) Similar to the preceeding paper but arranged differently.

36. Kline, Nathan S. (Letter to) Long Binh, 1967. Some inside observations on the structure of civilian psychiatry in Vietnam and the distorted perceptions Americans can get of themselves and of the psychiatric problems in Vietnam.

37. The Use of the Local Community's Own Energy and Intelligence in its Mental Health Programs (Saigon, 1967) The most effective mental health centers seem to be integrated into the local community and managed by community leaders. It is largely the informal support systems which provide the greatest help to patients.

38. Taste, A Necessary Ingredient in the Genesis of Civilization? (Saigon, 1967) The core cities from which civilization spread to other parts of the world where developed in places where the techniques of irrigation were necessary in order to maintain the concentration of population. But in one center, the Yellow Plain of China, irrigation was not required for food itself but only for wet rice. Could the taste for this sort of rice have driven a population toward civilization?

39. The Social Nervous System (Long Binh, 1968) The "electric circuit style of thinking" has relaxed its hold upon the neurologist's imagination and now it is reasonable to conceive of the central nervous system as in large part a system of shifting and shunting humors which extends by both physical and chemical means outside the boundaries of any individual body and knits together a social network.

40. Man-team-environment Systems in Vietnam (Long Binh, 1968) The unfeas-

ability of considering a person or a military unit as an interchangeable part in the Vietnam theater of operations. More useful operational and training concepts are presented.

41. The Nomad and the Cultivator (Tay Ninh, 1968) This is a notation on "The Frontier in History" by Owen Lattimore. Some of the world's innovations arise at the dialectical interface of the important frontiers of the world such as that between China and Central Asia. Lattimore points out the normal succession of economy types on the Mongolian frontier.

42. The Megahospital During the TET Offensive (Long Binh, 1968) How the U.S. Armed Services utilized every hospital bed in Vietnam and every surgical team as if they were all elements of a single giant hospital at the service of each individual patient.

43. The Coming Unitary Life (Pleiku, 1968) A presentation of the ways in which many persons of Western society have expanded into the "unitary" person which L. L. Whyte described in The Next Development in Man. This contrasts with the dualistic thinking and dualistic personality structures which have characterized Europe for centuries. Sequential necessities for therapy.

44. A Group Psyche Model (Long Binh, 1968) We have traditionally practiced psychiatry as if we believed that desires, moods and creative thinking had its origin in the individual mind which is surrounded by the skin of a unique person. Yet, languages grow and change seemingly quite aside from the desires of any individual. Similarly corporate decisions are made which no one individual really wanted. Plans are made and styles are changed and no one can discover what individuals brought about these changes. An invention or a concept whose time has come will be authored simultaneously by several persons working in isolation from each other. It is uncomfortable to believe that the earth is hurled through space by cosmic forces or that the evolution of our species has proceeded by a lot of chance competitions and symbioses or that we do not as a nation control our own history or that most of our thinking processes proceed outside of our awareness. Until we accept one of these egotoxic principles however, we are blocked from making any giant step in that particular field. Until a body of psychiatrists (or perhaps some completely unrelated profession) develops its own group skill in practicing as if individual thoughts and actions were a part of a group process, we can only continue to polish up the small compassionately beautiful successes we have had in traditional psychiatry.

45. The Changing Field of Army Psychiatry (Denver, 1968) This address to social workers reveals twelve years of progress in military mental health practices. The progress in in-patient practice includes (1) the use of the entire ward milieu as a therapeutic tool, (2) the recognition and employment of patients as inevitable therapeutic influences upon each other, (3) the development of a much more normal duty-like atmosphere on in-patient services even while employing behavior modification techniques, (4) the psychiatric nurse as a promoter of decentralized "family" skills in maintaining mental health, (5) the decentralization and computerization of records and therapeutic methods. Twelve years previously the

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focus of psychiatry was upon individual pathologies treated within a great in-patient service. Now the focus is upon the mental health assets of usefully functioning groups and how these groups can better the functioning of individual members. The professional focus is not upon the great hospital in a centralized position but upon the informed consulting team decentralized into normal duty areas. These consultation teams determine who shall be treated in hospitals, clinics or within their own duty units. When mental health staffs and corrections staffs realized that they were both dealing with human suffering and human deviance, their cooperation closed four of the five army prisons and decreased by more than 50% the persons incarcerated locally. The work of consultation teams in Vietnam has cut the psychiatric casualty rate in this war lower than that of any other war in this century. Side-by-side, with Vietnamese psychiatrists, Americans are learning how a whole society maintains a very low rate of psychiatric casualties even though at the same time it has a "state hospital" system more antiquated than our own.

46. Vietnam as a Surgical Center (Long Binh, 1968) American military surgeons in Vietnam are getting extensive experience with problems almost never seen in the United States. Vietnam employs a new hierarchy of medical communication and transportation. It faces simultaneous surgery of multiple body systems, wounding from extremely high vilocity missles, sudden dumping of mass casualties on surgical teams. The interlocking system of consultation and collaboration is such that Vietnam is sending to the United States the world's best-trained trauma surgeons.

47. Marathon Group Techniques and Theories (San Antonio, 1969) This is an extensive elaboration of the marathon group principles which were partly brought out in A Marathon Group (Oakton, 1967). The illustrated paper contains numerous practical hints and suggestions as well as elucidation of the underlining marathon group theory.

48. How the Community Consultant Deals with the Structure of His Social Systems (Denver, 1969) All symptoms can be treated as communications from one system to another. This paper attempts to define clearly the client systems involved and the types of intervention which may be effective.

49. The Increasing Psychiatric Caseload vs Decreasing Staff (SGO, 1969) Military psychiatry is working more effectively with fewer staff by: (1) better collaboration with other professions and technologies; (2) Management of problems by consultation; (3) engaging family members, neighbors and other patients in the treatment process; (4) the conceptualizing of the problems as systems problems and the developing of increased responsibility within the natural living systems.

50. Army Mental Health Activities in Vietnam (Co-author Edward N. Colbach, Washington, 1970) A history of psychiatry in the Vietnam combat zone from 1965 to 1970.

51. The Military and the Civilian Psychiatrist--U.S. and Swiss (Zurich, 1964) Comparison of the preparedness of Swiss psychiatrists, all of whom are in the military, and U.S. psychiatrists.

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52. Psychiatry in Combat Zones (Washington 1970) History shows that training alone is not enough. A prestigious model is necessary.

53. Characteristics of Preventive Psychiatry Facilities (Washington, 1971) The model of intervention which seeks to remove pathologies within individuals is compared with the model which deals with epidemiology, with roles and styles of behavior within systems of living and production. There are some indications as to which model is more effective in preventive psychiatry.

54. Occupational Therapy and the Non-human World (with Barbara Bolinger, OTR) (Decatur, 1971) Three aspects of a patient's life and problems are dealt with typically by three medical professions--transactions with people: physicians; personal bodily life: nurses; the non-human world: occupational therapists. These three aspects of life are developed in the growing child, the healing adult, in group life and industrial life. Management and labor unions, hospitals and families, neighborhoods and churches may all collaborate to develop these three worlds for individuals and groups.

55. Drug Abuse: A General Orientation (Washington, 1971) Some fundamental definitions, drug effects and patterns of drug usage. Different communities benefit optimally by different patterns of management of their drug abuse. A dozen different pattern examples are presented.

56. Ways of Thinking About Your Work With Drug Abuse Problems (Columbia, Md., 1971) An illustrated paper presenting hints and admonitions concerning involvement with the "drug culture".

57. Notes on Death of the Family (Columbia, Md., 1971) Death of the Family was written by David Cooper, a disciple of R. D. Laing This paper unwinds some of the book's ideas and then spins off further notions and practices useful in this changing institution--The Family.

58. Mahan, Mackinder, MacArthur, McLuhan: Secrets Behind Modern Wars (Washington, 1971) How each of the wars of the twentieth century have been conducted in accord with currently unspoken principles which were seemingly outside the awareness of national leaders at the time. The growing schizm between the human and the mechanical aspects of war. The shift in importance between the military services and arms. How we always prepared to fight the previous war.

59. Post Industrial Consciousness - This is notes and spin-offs from the Greening of America, by Charles Reich. A somewhat optimistic view of the development of the young, new society in USA.

60.1. Neighborhood Cultures to be Considered in Planning Social Services (Washington, 1971) The cultures of country folk, the culture of city people and the consensus of professionals each have vastly different needs in their services. Most individuals however are composed of all three types of culture in different degrees.

60.2. Problems Among Neighborhood Cultures--An Example (Washington, 1971) This paper shows the vicissitudes of very energetic and socially useful black group which effectively controlled drug abuse.

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6o.3 Education in a Ghetto Nation. (Washington 1971)

61. The Marathon Group Movement: A Critique (Great Falls, Virginia, 1971) History of how certain effective and useful methods of group treatment had to die, at least temporarily.

62. The Use of Existential Concepts in Group Therapy and Training (Fairfax, 1971) How the fear of the loss of existence (or of great change) prevents effective therapy and how it even prevents the training and development of more effective therapists. How to utilize the helping rather than the hindering aspects of existential thought.

63. A Language Learning Group (Frankfurt, 1963; Chicago, 1972) This is an account of the experience of five Americans during about a year when they learned the German language by means of the techniques of group counseling. They followed the principles layed down by Father Charles Curran but modified these principles somewhat to fit their own situation and they drew conclusions not elsewhere written. They learned the language directly from objects in front of them, activities such as meals, games, and trips and from behaviors of others within the group rather from any English words. Some of the assumptions they were forced to make about language learning were quite radical and probably were not previously in the literature. This paper was originally written in 1973 but was consulted upon by Father Curran in 1972 when the author participated in the highly developed language learning groups at Loyola University.

64. Advantages of Learning Languages in a Counseling Group (Chicago, 1972) This is a sequel to the paper on the language learning group. It shows how in one hour a student may gain five or six times as much information and skill as he would gain in an hour of ordinary classroom recitation. Properly, therefore, more academic credit should be given. In both of these language papers, the inevitable psychoanalytic transference effects are considered.

65. Let's Tell the Vet What Happended To Him (Dallas, 1972) The majority of the population, that did not go over seas to war in Vietnam, employ several energic methods to insure that any opinions or techniques the soldiers have developed which are different from those of the stay-at-home population will be completely erased. There is strong expectation that a good percentage of the returning soldiers must break down psychologically because of this "immoral" war. Since very few broke down in combat itself society provides expectation-pressure for them to break down after their return in order to save the society's pre-formed opinion of itself and of southeast Asia. Because of such social needs, new disease may come into existence--such as Neurocirculatory Asthenia. If only the soldiers would behave in a more guilty fashion they could relieve a lot of the anxiety of the civilian population. An extention of this thesis is that since more than one percent of the US population had gone to Vietnam, the rest of the population stood in danger of being converted in their attitudes and mores with regard to the family of nations in which it lived. Those millions of soldiers were even more dangerous to the culture of Vietnam itself--especially north Vietnam--for the soldiers were rapidly allowing south Vietnam to establish a mixed culture of east and west which was resistant to communism. Thus both US and Communist societies would do anything to get the American soldiers out of

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Vietnam and especially to make them look corrupt. The drug abuse peoblem, however, did not arise in Vietnam. Its main origin was New York city in the 1950's and it spread from there to the rest of the United States and thence, to the soldiers in Vietnam. Hard drugs did not become a problem in Vietnam until after 1969.

66. Uses and Meaning of Personal Individuality (Chicago, 1972) This essay goes back to the philosophical bases of the notion of separate and unique individuality for different persons. There has indeed been very real doubt among good thinkers that the individual as we popularly conceive it does not exist. It is no wonder that many therapeutic enterprises are unsuccessful if we are treating something that does not really exist in the way that we conceive it. Possibly, it will be more effective to treat the social origins of "individuality"--as will be brought out in later papers.

67. Neighborhood Network Intervention (Bethesda, 1972) Following the general principles of Dr. Ross Speck, this paper gives a case illustration of how a neighborhood may convene around a problem which exists within an individual or between and some of his friends or relatives. This is an extremely powerful and practical form of intervention. There is, however, almost no way adequately to fund this sort of therapy. Such public mental health services would require coordination between two or three separate sorts of agencies. For instance, an in-patient center might have to cooperate extremely closely with an out-patient center. The result would be that both centers would have to revolutionize a part of their own methods of working. A social worker and a psychiatrist from an out-patient center could help a neighborhood convene around a problem, but the scapegoated indicated patient might be in a hospital. The hospital workers would want to have alot to say about the patient as an individual and might find it hard to commit themselves to the neighborhood network.

68. Historical Individuality Types and Their Relation to Family Network Psychotherapy (Chicago, 1972) This paper attempts to free the therapist's mind from the narrowest stereotype of "unique individuality" by illustrating differences in individualism manifested in the Middle Ages, Renaissance, Victorian times, etc. There are also differences in the type of individual found in corporate and entrepreneurial life as well as between various kinds of neighborhoods such as rural, ghetto, suburban, nomadic, etc. Family network therapy allows for practical intervention with these various types of "individuality".

69. Isomorphies: Physics and Social Psychology (Chicago, 1972) This paper itemizes some analogies of recreational value which exists between the laws of physics and of group psychology, political structures, actions, etc. Thus, the temperature in a room and the pressure against the walls varies in accord with the number of people who may be crowded into that room. In addition, the laws of thermodynamics can apply as well as the laws of mass action, ionization, gravity and the laws of nuclear physics.

70. Organizational Consulation Notes (Leicester, 1964; Chicago, 1972) Following principles largely elucidated by Cyril Sofer at the Tavistock Institute, this paper outlines a method of consultation to industry and other organization in order to effect useful changes. This is mostly a basic traditional and

conservative model although it is not well understood by a great many "consultants".

71. Types of Group Therapy (Decatur, 1972) This is a short paper on group therapy as opposed to individual therapy in a group. All psychotherapy is assumed to be a group therapy of some sort. Some therapy just happens to concern itself with very small groups such as therapist-patient.

72. A Veteran of Three Wars Looks at Psychiatry in the Military (Chicago) December, 1972. Certain social forces cause us to develop theories and to forget our experiences that seems contrary to those popular theories. The "military psychiatrist" is then compared with the "civilian psychiatrist" and a series of stereotypes for the military psychiatrist is discussed and evaluated.

73. A Psychiatric View of Economics (Chicago, 1972) Activities and goods which effect mood changes are seen as the basis of most modern economics; for example, drugs, food, sex, violence, entertainment, work, religion, new information, etc. The production and management of every one of these mood changes can border upon mental illness. Many of the mood changes are interchangeable with each other, but certain mood changes have vastly different effects within a society than others have.

74. Modern Changes in Concepts of Both Teaching and Counseling (Chicago, 1972) Both the teacher and the therapist or counselor have tended to become "incarnate". The worth of the student, the patient, or the common man has become more realistically level with that of the teacher and therapist. There is a new understanding of group dynamics. Therapy and education are seen as virtually equivalent. Certain informal methods including student-to-student methods have greatly accelerated the pace of learning. In fact, all of the above developments have changed--and in general, have made possible the acceleration of learning.

75. The Place of Family Therapy in General Psychiatry (Chicago, 1972) In the past 100 years, mental health interventions have concerned themselves first with the difficulties of unattached individuals. Then it has considered the problems of individuals as members of a family. Then it has considered the family itself as the organism with the need for therapeutic intervention. Then it has considered the community as that organism needing intervention and at the same time, the organism which can best provide therapeutic intervention. All of these assumptions and modes of intervention have remained viable till today. The effectiveness of the later methods is much greater today than at any other time, but the older methods remain more "popular".

76. Management and Monotheism (Kokomo, 1973) Our tradition of pinning the highest respect, the highest power, and the highest accountability onto one person such as the father, the boss, or God has resulted in an inability to manage collaborative responsibility. It has also made it very difficult for communities to accept responsibility for their own mental health problems.

77. Existentialism - A General Psychiatric View (Chicago, 1973) Existentialism affords a powerful defense against the modern tendency to see the individual as always having been less autonomous than he thought he was--especially in

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the Western world. The development of existentialist thought is traced through the past century or two during which time it has altered itself in accord with the needs and problems of the times. It is now quite influential in psychotherapeutic interventions.

78. Clients and Cabbages (Chicago, 1973) Management sometimes deals with the flow of work and the allocation of resources as if it were dealing with cabbages rather than persons. It is not hard to develop attitudes which will preclude this. A stylish misinterpretation of "management by objective" and a fear of loss of control by decentralization has led management in many cases to get into the cabbage business.

79. Resume of General Systems (Rockford, 1973) General systems theory is a sort of algebra which simplifies the planning of therapy, games, politics, production, marketing, etc. Using a basically biological point of view the theory considers all systems as part of some larger system. Within and among systems there are many common patterns and mechanisms such as input, output, feedback, servos, genetic codes, clockwork, matrices. Some social systems eventually become so stabilized that they act as if they believed they would remain the same for ever. Others seem to see themselves as in constant flux. The planner with his algebra steps outside of all these notions and deals with them as he would with mathematical or biological structures.

80. The Case of the Rockford Consultants (Decatur, 1973) Frontline workers who helped to develop a "lodge" for rehabilitating mental health clients were brought as consultants to workers in another r.;ion of Illinois who had similar responsibility. Symbiosis among peers within a region develops and alters the kind of consultation which can occur from outside. There is an interplay here between objective and subjective attitudes toward the lodges and their missions.

81. Seminar: Social and Preventive Psychiatry (Chicago, 1973) This is an outline with special annotations of a course conducted with second year psychiatric residents in the University of Illinois, Medical Center, Chicago. Certain major responses of the residents are presented.

82. The Boundaries and Pivots of Individuality (Chicago, 1973) The sense of personal individuality is a balance between (a) self contained within a boundary which separates it from other selves and (b) self separated ultimately from no one, but pivotally centralized as a core of personal meaning more closely identified with some selves than with others. The first type of individuality predominates in Western Europe; the second type in East Asia. These types of thinking have a profound influence upon European as against Asian attitudes toward mathematics, art, science, politics, language and therapy. Therapists cannot clearly understand one point of view about individuality and self without understanding another.

83. Harvard Consultation Notes (Cambridge, 1973) These are notes taken in a course on psychiatric consultation taught by Gerald Caplan at Harvard University. The development of support systems is discussed with many case examples of consultation with both individuals and organization. Some of the consultations are international; they use principles or management, education, general systems, theory, and social psychology.

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84. Modern Education: Its Aims and Effects (Chicago, 1973) The actual goals of education, as derivable from the behavior of education systems, are quite different from the expressed goals and probably come into being outside the awareness of most educationists. The risks involved in modern education are so great that most of us shut out eyes to where it is leading us. The results are probably not bad nor good. They are frightfully different from what we expect.

85. I Worry About Marshall McLuhan (Chicago, 1973) The view points of McLuhan concerning media of communication and their effect upon society and individual thinking are summarized. Extrapolations are made describing the different sorts of creative thinking which occur when the thinker utilizes mostly a visual, or a tactile, or an olfactory world of communication.

86. Family Management Unit (Rockford, 1973) This is a brief summary of the work of a small residential treatment unit for children and adolescents.

87. Long-term Patients: Lodge and Phoenix Program at Singer Regional Center (Rockford, 1973) Chronic patients who have burned out all their local social support and are rejected by all the citizens and will not live alone or perform a normal job are "cohorted" into a group within the center. When this group is somewhat self supporting, it moves out to a "lodge" in the town. A staff member then acts as counselor and business agent helping them get jobs and to manage their earnings. Traditionally trained staff are usually not very effective at this work. Some suggestions for training are given.

88. Notes On My Reading (Chicago, 1973) This is a discussion of the ideas in certain books which seem currently relevant to mental health work in Chicago. The authors discussed are McLuhn, R. G. Collingwood, Hannah Tillich, Michel Foucault, J. K. Galbraith, Ruth Caplan, M. A. Lieberman, et al.

89. History, Drama and Living: Collingwood, Stanislavsky and Moreno (Springfield, 1974) Collingwood tried to understand history in terms of the "inside" of its events--not merely the event itself but the social attitudes that gave meaning to the event and which indeed helped to produce the event. Stanislavsky trained his actors to review in their hearts the entire life of the character they portrayed. Even though the past life was not entirely manifest on the stage, it influenced what occurred on the stage. The actor was trained also to fit his own pecularities of character into the role. Moreno's staging unfolded the inside feeling and social forces which gave meaning to the pains and conflicts within a family or individual. By staging the "inside" in psychodrama, in history and in life, we change it and change therefore our own behavior and feelings.

90. The Work of a Systems Intervention Team (Champaign, 1974) Case examples show how a symbiotically collaborative team intervenes in coherent, but pathological, social systems to effect permanent changes.

91. APA Convention Notes: Bazelon, Toffler, Bucky Fuller (Detroit, 1974) Judge Bazelon showed the advantages of the adversary system and how some court decisions had been misinterpreted and misapplied so that their effect was negated. (e.g. Durham). Fuller and Toffler present somewhat disconnected

but useful insights about the future we are heading for.

92. Existential Therapy: Notes (Chicago, 1974) This is a short summary of the use of existential concepts in therapy which is particularly useful in the corporate and bureaucratic life of today.

93. Social Regression in the Service of Therapy (Rockford, 1974) In medical and surgical problems we often cause the patient to "regress" into bed rest or hospital life in order to help the medical problem. It has been very hard for us to accept the fact that for psychiatric problems such regression has been largely harmful. Grants-in-aid have some regressive effects upon communities but when handled correctly they have the opposite effect and led the community to take effective responsibility for its own rates of delinquency, mental retardation, accidents, etc.

94. Modern University Problems (Urbana, 1974) The modern university is forced at once to be elitist and egalitarian. It is forced to respect the student's subculture and to promote its development. At the same time it reacculturates the individual, it may destroy the person he once was. It gives people the power to earn money for themselves in order to maintain the traditional ways of business and society. At the same time, it gives them an academic and persuasive skill which is worth very little money but has power to alter traditional ways and even bring about whole revolutions. The images developed by universities alter the mental health status of the society. Yet, the university itself is in danger of extinction.

95. Improving Personal Health by Looking Beyond the Individual (Chicago, 1974) Most of the illness we do not have to suffer today is absent because of changes in social rituals, attitudes and physical surroundings, not because of techniques for treating individuals after they get sick.

96. The Politics of Mental Health (Rockford, 1975) The populace often uses political machinations to provide rhetoric, architecture and role-assignments in an attempt to convince itself that it can eliminate its own responsiblity for its own mental health problems.

97. Milieu and Therapeutic Community: A Message to the Nurses (Rockford, 1975) This is a short review of the history of milieu therapy as it developed at Walter Reed, Fort Logan and other places. It amounts to an adjustment of the climate in which the patients live together. A proper climate with proper techniques employed will provide optimal opportunities for each patient to improve according to his own needs. The therapeutic community, on the other hand, is a social structure in process of constant redefinition and constant managerial pressure from the total group of patients and staff. Treatment is not really provided nor delivered, it is lived through. The history of this type of treatment is traced from Northfield, Henderson and Dingleton in Great Britain to Oak Knoll, Fort Logan and others in the U.S.

98. Concepts of Nursing (Rockford, 1976) Nursing is developing into a more self sufficient profession on its own which tries especially to develop self care in patients, families and small communities. Nurses are becoming astute orchestrators of the milieu and facilitators of inter-patient communication and role exchange. Diet and medication for instance are considered only two

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of the influences upon the milieu which are eventually to be handled by the patient in his self care development.

99. Schizophrenia (Rockford, 1974) This is an outline history of the development of the definition of schizophrenia and the attitudes toward schizophrenia which lead to the current styles of treatment.

100. The Anxiety Styles Which Guide Economic Life (Rockford, 1976) When we are anxious about heaven and hell we spend our money and our energy on churches, crusades, etc. When we are anxious about our identity as individuals we spend our resources on a different array of "solutions". In either case, we are likely to bankrupt ourselves.

101. The Changing Concepts of Self (Rockford, 1976) Whether a person has an individuality distinct from all others, whether he has a constant core of character throughout his life, whether his distinctiveness is determined by others or is inborn, whether there is even such a thing as the self at all, is a matter for current world fashion to decide. A half dozen types of self are described--each of which belong to different periods of history. Illustrations are given from a dozen key critical writings. A therapist or a manager who can free himself from the traditional fixation upon a certain contemporary type of self has the opportunity to develop better education, therapy, administration or child rearing.

102. Nosogenesis: Demons, Microbes, Psyches, Polities (Rockford, 1976) People in the middle ages thought diseases were caused by demons which were supernatural spirits. Later, the demon became a chemical or physical influence. By 1800 it could even be the lack of some influence such as a vitamin. Later, microorganisms were implicated. By 1900 the demons could be simply intrapsychic conflicts. Today each of these demons remain popular in various circumstances. Political forces, however, have become especially powerful causative agents today.

103. Anna and the Ego (Rockford, 1976) A review of Anna Freud's Ego and the Mechanisms of Defense with many illustrative examples.

104.. Ann-otated Bibliography--Psychoanalysis: Ego Psychology (Rockford, 1976) This is a set of commentaries on half a dozen key ego psychologists writing from the 1930s to the 1960s and employing a psychoanalytic viewpoint. (Written for a young physician named Ann).

105. Ann-otated Bibliography: Community Psychiatry (Rockford, 1977) Twenty-five key papers from the 1950's to the 1970s are briefly evaluated. They include the development of informal support systems and neighborhood therapy, some included evidences back up communication theory and certain anthropological approaches to the problem of modern psychiatry.

106. Alcohol: The Tribal Blood of Modern Business (Rockford, 1977) In spite of our condemnation alcohol has become almost essential to the conduct of modern business.

107. My View of Community Mental Health (Rockford, 1978) This paper reviews the stages and the development of mental health care which lead ultimately to the

local community's taking useful responsibility for its own problems of non-effectiveness. Also included is the management of patient problems within the local community.

108. Support Systems in Special Education (Minneapolis, 1975). The aloof objective professionalism of some teachers is contrasted with the necessary warm subjective professionalism required in special education. Client participation in administering the service also alters the type of professionalism. Special education has certain resources which enable a local school to keep up with and integrate itself with the advancing national service.

109. The Ultimate Economic Development: (Madison, 1978, 1980)
A. The Delusion of Economic Growth
Material growth at 6% over a period of centuries is impossible. Material enterprises grow only at the expense of others.

B. The Real New Wealth
National wealth, once defined as the annual production-consumption turnover, becomes redefined as the total creative communication within a consensus. It is no longer wise on Spaceship Earth for one group to exploit another by a "favorable balance of trade". With collaborative innovation mankind has often escaped the squeeze of entropy but necessarily by bringing about the demise of some institutions and some dear beliefs.

110. The Nature of the New Modern Mind: The Extinction of Causation (Urbana, 1978) Since the 18th Century the more vigorous western philosophers have found untenable the popular notion that one thing causes another by direct one-to-one influence. There is no longer any absolute truth but only degrees of confidence. Cause and effect has become a comfortable metaphor like "sunrise". We know the sun doesn't move but we don't care.

111. Expendo Ergo Sum A client exists clearly within a therapeutic relationship to the extent he pays in one way or another. Therapeutic skill for families, neighborhoods or small communities develops erratically because professionals are not paid in the name of such groups. Yet this kind of therapeutic skill is the most needed. Since most professionals avoid experiencing chronic psychiatric hospitalization or even the natural ghetto life, they make little progress in the therapy of the chronic and the poor. This can be remedied. (Chicago, 1972)

112. Man The Eternal Symbolizer: Notes stimulated by Suzanne Langer's Philosophy in a New Key. (Leavenworth, 1961)
Personal ruminations about the nature of thought and belief as awakened by a great philosopher.

113. The Media - Their Effect on War and the Thought Market: Modern reasoning and the development of ideas is accomplished not only by intercommunications among the cells of ones brain but also by intercommunication among TV stations, newspaper publishers, ticker tapes, etc. This set of inter-

communications produces depressions, wars, musical compositions or religious revivals. Today's media bring such results faster than yesterday's. (Chicago, 1975)

114. Combat Psychiatry in Varied Settings (Monterey, 1980)
The soldier with normal reaction to battle stress must be protected from diagnosis and from loss of his military unit. The Zone of the Interior stands ready to cripple him with a stereotyping diagnosis and to damage his personal identity by giving him the best of institutional care. The preventive and restorative forces of combat psychiatry can be applied in problems with disaster, terrorism, hostages and prisoners of war.

THE USE OF MUSIC IN GROUP THERAPY

Presented at USAFFE Medical Conference, Tokyo, 1955

Captain Matthew D. Parrish

THE NEED: Often in group therapy, patients attend several sessions without being more than superficially acquainted with each other's potentials of thinking and feeling. They are slow, accordingly, to develop confidence in their own skill in thinking problems out with others. Here, listening to music together was used to bring about quicker mutual understanding of feelings.

THE METHOD: A piece of music about five minutes long was played to groups of four to eight patients while the patients made notes of their feelings, if they desired. Then each patient in turn related feelings about the music. The groups included patients with average intelligence or higher, with diagnoses of neurotic disorders or schizophrenia.

RESULTS: Mental association to the music ranged from reminiscence of being in church as a child to dramatic story of two lovers meeting in a moonlit Texas desert, journeying happily through the night, and parting sadly with the sunrise. Occasionally, patients criticized the music, saying it made them uncomfortable. These feelings would be discussed by the group. Others wondered why one patient felt so much in the music and another so little. One group was impressed with the vividness and complexity of a schizophrenic patient's associations while in a sub-acute stage of the illness. On rehearing the same music a month later, the group was further impressed to find this member relating a new but more limited set of associations and professing complete amnesia for her more imaginative association. An example of one patient's associations is as follows:

"I see a ballet dancer on a stage, alone, with blue lights and silver background--stark background. She dances as though searching for someone or something; and as the music gets faster, there is a faint hope she has found what she looks for; but the music slows down and she droops with disappointment. She keeps on dancing, halfheartedly, for she has lost hope and remains alone."

TYPE OF MUSIC EMPLOYED: The music was always a single movement of a string quartet. Music which brought obvious "popular" images, such as cuckoo birds or fog horns, was avoided. Attempt was made to standardize associations to the "Cavatina" movement of Beethoven's String Quartet, Opus 130, but after eight playings, no "popular" pattern responses have been apparent.

DISCUSSION: 1. It is possible that some music could be standardized and used as a projective psychological test, perhaps as the Rorschach is used.

2. Of more immediate clinical value is the insight this music gives group patients into each other's ways of feeling and the stimulus it gives toward ready discussion of their subtler emotional life. In helping patients perceive each other's feelings, the groups found music more quickly effective than ordinary discussion.

REFLECTIONS ON GROUP THERAPY

Matthew D. Parrish - Ft. Belvoir 1959

I. THE INDIVIDUAL PATIENT AT THE BEGINNING OF GROUP THERAPY IS USUALLY UNCOMMITTED --

1. He determines to share no really significant experience with these other people.

2. He interests himself in the fate of others only for the clues it gives him to solve his own problems by himself.

3. He participates in this mildly interesting group farce only to play along with the doctor so doctor will show him a gimmick he can use to solve the problems perhaps after doctor gets some further information.

4. He feels rivalry as others take up the doctor's time when he would like to have it all for himself with no fooling around.

5. He under-rates the troubles of other patients and over-rates his own.

II. AS GROUP SESSIONS PROGRESS CHANGES OCCUR IN THE PATIENT --

1. Sometimes patients begin their first minutes of group therapy by hurrying to identify with each other all over the place. Therapist usually makes use of this realizing it is pretty superficial and transient, but that underlying this is still a process of group growth.

2. Patient does appreciate the tolerance of the others and returns it.

3. He thus finds himself involved as a <u>member</u> of a group of rivals and sees himself as taking up <u>group</u> time.

4. He sees the similarity of his own with others' problems.

5. He relates to others by identification, "I understand you". "I'm over there feeling what you feel just as if I were you"--a primitive method of emotional interaction which members will eventually outgrow. But in doing so they develop more breath of understanding and empathy than they otherwise could.

III. TRANSFERRENCE IS WITH THE DOCTOR THOUGH PSEUDO TRANSFERENCE EXISTS AT TIMES BETWEEN PATIENTS

1. Doctor may be in succession; Father, Mother, sibling etc. to a patient.

2. Doctor also passes through a succession of transference relations with the group-as-a-whole. The group-to-doctor transferences are fewer and simpler and lack some of the subtlety changing nuances that the patient-to-doctor transference has, but the patient's participation in the group-doctor transference is very intense because patient is swept along by the group emotion.

3. Positive and negative transference feelings are usually expressed openly.

4. The emergence of an autonomous emotional life - a strong ego - from this group transference makes the patient much more aware of his emotional coercion from society than individual treatment does.

IV. EMOTIONAL EXPRESSION BECOMES FREER

1. The relation of patient to doctor is always stronger than of patient to patient.

2. This strong relation allows free expression of feeling between members - reminiscent of hypnosis or the psychoanalytic couch where some patients say they are free to remember because the doctor shares the responsibility of any embarrassment.

3. Rivalries between patients are therefore, openly and safely expressed in all their nuances.

4. The strong tie to doctor also prevents too much acting-out between members outside the therapy room - e.g. homosexuality, gossip.

5. At first members become cast by their relative personalities into cultural roles for the group - the philosopher, the executive leader, the favorite child, the personification of Death etc. But these are pseudo-roles which eventually fall away as the group becomes more cohesive and fixed roles are not needed. Each member eventually participates as a flexible self taking up any part.

6. In this freedom individual problems of guilt, anxiety, dependence are brought to individual solution at the group-patient-doctor concurrence.

#3

TECHNIQUES OF GROUP THERAPY FOR SOCIALLY AMBULATORY ADULT PATIENTS*

Matthew D. Parrish, Major, MC**

Goals: (1) Relief of individual symptoms causing impairment of human relationships e.g. depression, delusions, aches and pains, obsessions, fears, seclusiveness.

(2) Change in attitude and methods of interpersonal operation between people in a family, company, or business so that life and work become more healthy and productive.

Size: Usually 5 to 10 patients present (more may be on the roll of membership).

Group Composition: (See Knighton's contribution on this.) In general, it is well to have a variety of personalities--a couple of fairly reactive energetic and verbal members should be present. Also, a couple of skeptics as well as one or two who can put themselves rather easily in other peoples' places. Age, diagnosis, and social position are not in themselves important.

Model Technique: In the first meeting say nothing. Just walk in and expect the patients to introduce themselves to each other in some way and to find their own seats in the prearranged chairs. By non-verbal activity get the patients to interact as feelingly and freely as possible.

Objection: This method is a threatening one to therapists who are uncertain of themselves (they usually say it's too threatening to the patients). It works best with an analytically trained therapist who has great patience, humanity, and psychic aplomb--such as a Frieda Fromm-Reichman or a Curtiss Knighton.

The following techniques may be found useful as needed by the more average therapist:

1. Making a Pitch. Give a short lecture on the goals of the group, the times of meeting, and the special rules for

2. Going the Rounds. Each patient in turn briefly characterizes himself and his problem.

3. Checking Each Other. Each patient characterizes the patient on his left. (Remember that in so doing he also characterizes himself.)

* Extracted from the Fort Belvoir Mental Hygiene Bulletin, April, 1960.

** Chief, Mental Hygiene Consultation Service, Fort Belvoir, Va.

4. Throwing a Problem Out. In throwing a problem out to the group "See if you as a group can get to understand from Joe why he came here....(or) what Joe means by what he just said....(or) what do you think this means to him?"

5. Projective Techniques.

   A. Show a TAT card to the group and have each member in turn tell a story about it. Patients then quickly learn about how the others feel and how their own feeling compares.

   B. Play a 3 or 4 minute piece of recorded music and have patients free-associate about it. (The Cavatina of Beethoven Quartet #13 is fairly unstructured, non-program music which is being standardized for this purpose.)

6. Therapist's Non Verbal Control and Responsiveness. Look toward a patient. Lean or hold a hand slightly toward him. Or touch his chair with finger, foot, elbow, etc. Shift your weight toward or away from a person or object - like the door.

7. Making Patients Aware of Their Effective Operations.

   A. Imitate the pitch patterns of a talking patient - or - of the group feeling - this can be done vocally or instrumentally (cello, viola, kazoo).

   B. Translate the real meaning of individual or group feeling into simple or allegorical words - "I hate you, Joe"; "We surely do miss Joe." This can become a running "strange interlude" commentary for a minute.

8. Leave the group and stay away 5 or 10 minutes until a dead group can get together over their common feeling about this action.

9. Rearrange seating in the middle of a session.

10. Go to sleep!

11. Bring a new member into the group.

12. Have everyone sit on the floor in a very close circle.

13. Seat one member in the center of the ring, preferably on the floor.

14. Put one member to bed while the others sit around him and conversation continues.

15. Use psychodrama techniques e.g. dramatizing and reliving a family quarrel, role reversal, alter ego (stand in) or 2 patients may play the id and super ego of a patient as he talks, etc.

16. Therapist as Patient: At a signal the co-therapist may assume role leadership while the other therapist interacts, tete-a-tete with a patient.

17. Group Therapy in a Telephone Booth would be ideal. But some large groups of people especially afraid of their own feelings may be conducted in a small room adjacent to a large hall into which patients may wander and return.

18. Fireplace Therapy. (Thorpe) Group meets in a semicircle around a blazing hearth in a darkened room.

19. Latrine Group. Group may meet for 10 to 20 minutes in a latrine. Especially when they go in there to get a member and talk him into returning to the group.

20. When one member of a group is resistive about his relation with, say, his wife, bring the wife for a couple of sessions.

21. Encourage the Group to remain for 15 or 20 minutes discussion after the therapist leaves. This makes more group solidarity.

22. When a patient or the group brings up a situation you don't know how to handle, then sit back, experience your own frustration more keenly and the group itself will come up with an answer.

Group therapy is supposed to be rewarding to patient, to group, and to therapist. Flexibility and innovation with recording, staff discussion, and followup make groups grow more effective and more interesting.

THE DYING PATIENT IN THE MENTAL HEALTH SERVICE:

A Recording of a Staff Conference at an Army Mental Hygiene Consultation Service, April, 1960

Matthew D. Parrish

Psychiatrist presenting the case:

The patient died a few months ago, but when she came to us about five years ago she was the 30-year-old wife of a lieutenant colonel. She actually came here, her story was, because she had a lump in her breast. She came to the outpatient clinic and a doctor said, "You don't have a lump in your breast, you can go home." She came back a month later and said, "I still have that lump," and at first the doctor said, "Oh, go home," but finally he felt it and then she said he was aghast. He said to her, "What are you doing going around with a thing like that in your breast? We're going to have to take it out right away. Come to the hospital tomorrow." In a few days she had a radical mastectomy on the right side. In the hospital, she was a terror apparently--to the nurses, to the doctors, everyone--and yet, she was the kind of woman that Colonel W., the Chief of Surgery, would ask for advice about people. After she left, Colonel W. had another patient who was similarly upset. Mrs. R., our patient, happened to know her and when Colonel W. asked her, "What did I do wrong with that woman?" Mrs. R. answered, "You didn't tell her she had cancer--not really. You just mentioned it and you performed a very terrible operation on her. You probably saved her life but you didn't really talk to her about the fact that she had cancer and what that meant to you and to her. You were never close to her except in an expert mechanical way."

Well, she was a very demanding and controlling kind of woman who generally got what she wanted. She was fairly attractive. I don't think you would call her beautiful but attractive enough, with just a slight tendency toward chubbiness. She was very bright and maintained an alert attitude, talking straight to your eyes most of the time. She usually maintained a rather serious attitude, but often underlay it with a barb of sarcasm.

She was the older of two sisters, reared in the deep south. Her father was something of an alcoholic, or at least he got to be one after marriage, and left home two or three times. She described her mother as a very selfish woman who had big ideas for her daughters to go to all kinds of elite schools. They were too poor to go. But anyway they had those thoughts. The daughters were brought up to marry some sort of millionaires or nobility. Mrs. R. struggled through a lot of bitter rivalry with her younger sister, a rivalry lasting practically her whole life. Eventually Mrs. R. married a general's son who was later killed in combat, leaving her with a 4-year-old daughter and a posthumous Congressional Medal of Honor. After he died, she came to believe that she wasn't even married to him, that he had been married before and that his divorce was not legal. Probably she really was legally married to her husband but she had this doubting feeling about it anyway. A couple of years later she married her present husband, whom she thought of as a very driving, demanding kind of man who didn't have much self-confidence but who had a lot of bluster. He would bang his fist through the door when he got mad at her and then she would laugh at him. Apparently she was very hard to live with, and all this was going on when she got the breast lump.

Since she was all upset about her radical mastectomy, Dr. H., the psychiatrist, was called in to see her. He at that time maintained an office in the hospital as well as his main one out here in the mental health service. He saw her once or twice a week for a few months as an outpatient, and then he put her into his group when it formed. This group started about two and a half years ago. It met on the ward once a week. She said she fell in love with Dr. H.--very deeply--and she was just in a turmoil about this because, she said, "Here I am in love with a Negro doctor." He was very kind to her and she couldn't get over that. She had within herself almost every feeling for this man--more, she said, than for anyone she had ever known. The only other person who came near to it was a Negro servant who took care of her from age 2 to 5 and gave her the most love and personal concern of anyone in her childhood. She always had very fond memories of this woman and said that really this was the kind of undemanding love that no one else had for her. Her sister had an ax to grind, her mother had an ax to grind, her father was always gone, there was always competition with the neighbors, but now came another Negro who gave her so much again. She was very demanding toward him and he didn't know what to do with her. His big problem was Mrs. R. all the time, although he had lots of other patients. Then Dr. H. went on a long leave to Europe. He came back for a while but didn't really treat anybody, and finally left the Army. Mrs. R. was awfully mad, but she was also sort of mourning for him.

A couple of months later her husband brought her to me and said, "Mrs. R. is really hurting and she has got to have a cure! Give her a cure, even if it lasts only for a month or two, just do something with her. See her every day for a month and see if you can cure her." And I said, "I can't see her regularly now, I can only see her once or twice." So she said, "How about your therapy group?" So I sort of fell for it and let her come into the group. The first time she was there she just sort of warmed up to the group, but the second time she saw a great deal of power struggle in there with those other women (there were no men patients in the group except at times by special invitation). She flew off the handle and got very hostile to them, but some of them put her in her place. My attitude was, "So what? They put you in your place," and this, to her, was just too unconcerned. But the next time or two she began to fit in better with the group and was sort of needed as an essential member. It went along pretty well most of the time. Once in a while she would fly off the handle. After about two months of weekly group therapy I began to see her individually two days a week, in addition to the group therapy sessions with me. At the same time, her husband got into the men's Saturday group. Things seemed to improve a bit and then a few months later (about two years ago) she brought her 12-year-old daughter along. She said, "My daughter just doesn't know what to do. She doesn't have any real mother. I can't pay any attention to a daughter, I'm too sick myself. So see what you can do with my daughter." So I said, "Don't do anything. Just send her to school." But Mrs. R. was all interested in getting this daughter to the best elite school (maybe as a repetition of her own suffering). I saw the daughter only once, but in a few months Captain M. and I formed an adolescent girls' group into which this daughter would fit. She did well. This was a relationship she had apparently never had before, the ability to say anything she wanted to girls her own age. They really took her in, and she came weekly for about three months. Mrs. R. and her daughter became much more pleasantly interested in each other.

Meanwhile, Mrs. R. was very anxious to read about psychiatry. She wanted me to give her psychiatric books to read--just wanted to cram all that stuff in. I suggested she talk to her husband more and pay attention to her family, but she kept complaining, so I said she should read Dostoevsky or other writers like that, but she had already read most of him, so I said, "I'll let you read a book or two I have." So I brought her Homer's Iliad and a few other books. All these delighted her. She would want to take two books at a time, but I would never give her but one. At the end of the week she would have the whole book read and she would take voluminous notes. She did this for about fifty books. She would say, "Eventually I'm going to Germany, Italy, etc. and I'll see all these places these books are talking about and these places where all these people live." As the time drew near for the family to be transferred to Europe she would get mad at me and would usually say that I picked on her and made her look bad in front of the group--made her reveal her true self, which she didn't want anybody to see. I made her look bad, she got off on the wrong foot with that group and was always second-rate, etc.

Nevertheless, the family left for Europe in good spirits. They traveled around Europe for about sixty days before they finally settled down to the husband's tour of duty. In the next months Mrs. R. traveled around Europe quite a bit by herself. She had a part to play in the military community and she played it very well. Apparently she was more well liked than she had ever been. She was a sort of queen among these people.

Then her dispensary gave her a chest X-ray for some routine reason. They found big blotches on her lung and they said, "You've got lung metastases. We've got to send you back to the States." She didn't go back, but she settled down, didn't travel any more. She thought, "Well, I'll just go along with a little more psychiatry." So she got a German psychoanalyst to treat her, and she said he was great. He didn't want her to go back to the States. He said, "There's no sense in going back there. You're not going to die for a while anyway. You may as well stay here." Some other people said the same thing--her husband, his commander's wife, etc. She continued to do her part well in the life of the community. Eventually the dispensary sent her to a big Army hospital for a checkup, and some people in the hospital thought she must go to Walter Reed, so they sent her back. At Walter Reed, the doctor said, "What are you doing here? There's nothing we can do. Just go home. When you get real bad we'll put you in the hospital and let you die." Of course, that's probably not quite the way they said it, but that's the way she remembered it.

Well, she tried to get herself referred here to the Mental Health Service, but Walter Reed would not refer her to Psychiatry at all. She was mainly under the care of a radiologist. She said, "I go to that man, but you know, he's not interested in me, he's interested in that machine." So she came out here on her own, without a referral. She said I was the only person she really felt comfortable with. I think what she meant was that I was the only one she could really get good and mad at if she wanted to, and not have too much trouble about it. Anyway, about 14 months after I had terminated treatment with her, I started seeing her again about once a week. She was mad as heck because she wanted to see me every day for six weeks. She said she had only about four months to live, or some such time that she made up, and she wanted to get well in six weeks and then live the rest of her

life. The doctors had told her at this time that her life expectancy was six months to a year and a half but she put death much closer. She figured she was going to die in three or four months so she was going to take part of that time to get well and part of it to really be happy with her daughter and husband. So I said, "That's for the birds, you don't do it that way, you live now. You can have treatment if you need it--that's all right. But you don't wait until you're well to start living." Anyway, she came. We didn't do too much that was different. Probably we didn't do as much in treatment as we had done before. She had a lot of argument about, "Why can't I come once a day instead of once a week?" At the fourth weekly session, I told her something had happened that I couldn't see her on the 6th session but could continue to see her weekly after that. On the next meeting, which was the 5th, she entered my office with a grim look and was carrying a package wrapped in brown paper. She sat down, pretty calm at first, but she kept working herself up into a tremendous rage over something vague--mostly that I didn't help her enough. Suddenly she screamed, "Oh, you're terrible!" She jumped up and started to flail at me. I would catch the blows on my forearms. I let a couple of them land--once in the face and once in the shoulder. I'm not sure why I did this. I think it had something to do with satisfying her. Anyway, she sat down and said, "I just can't do anything to hurt you." Then she grabbed my stack of unread electroencephalograms and threw them all over the room, very quickly before I could do anything. So I just sat there--EEGs all over my lap and everything. I said, "Let's talk about things." So, then she reached down for the third attack and picked up one of the EEGs and just tore it up into confetti and threw it all over the room. Then she sank back into her chair and cried. She just cried and cried and cried. Finally, she said she wanted to see me the next week (the 6th interview) and not be delayed. I said I wouldn't be able to see her then but I would see her every week after that. She said that she would just get herself lost and I wouldn't see her. Then she said she would see me again in six weeks. She started out the door, then she turned back, reached down and got her package wrapped in brown paper. She said, "Here's the book I bought you. It's Paradise Lost."

In this last office interview she went through the whole gamut of emotions. She was carrying out a sort of love at the end, I thought, but there was a lot of forlornness in it. I didn't see her in the office any more. Two or three days later she was in Walter Reed because she had become so upset. They X-rayed her and found she had multiple brain metastases.

I'll tell you my feelings in this, and my feelings are in a way more important than hers for an understanding of the situation. I thought at that time, "Well, this explains why she got mad. This was the only patient that was ever this mad at me--and tore me up, and all that stuff..." So it was all to be blamed on the metastases, you see. But then I said, "Wait a minute. Metastases make her kind of crazy and more uncontrollable." So then I felt guilty for blaming the metastases. Concerning other patients, I don't really think brain metastases cause specific behavior. A certain provocation might make them fly off the handle more easily but people don't fly off the handle just because they have brain metastases. They might even be very dependent and docile. I don't see why their behavior would have to be of any one type. The specific behavior would have something to do with the relationship with me.

Walter Reed sent her home but she had very bad vomiting. She couldn't keep anything on her stomach, was getting dehydrated. She wanted a doctor to give her something to keep her from vomiting, etc. So she came to our hospital and they admitted her. I saw her there but under the care of the internist the vomiting was becoming controlled. Her husband was hovering over her, solicitously, over-demonstrative. I saw her two times in the hospital. She was only there four days. Then she went home. I told the doctor and her that I didn't think she had to stay in the hospital. She said, "I don't think so either. I just want to stop vomiting, if I can, and get on my medicine all right and go home." The doctors had kept her on a little bit of thorazine and a little bit of some analgesic like demerol. Strangely, however, she did not become addicted to opiates, as far as I could see. She went home. She would call me on the phone every few days. She was in bed most of the time. Walter Reed gave her a hospital bed to live in at home, and a wheel chair and some other special equipment for bedridden patients. They also gave her a lot of advice and medicine and taught her husband how to give her shots. Eventually she called me up once a day. She would always feel closer to death each day. They told her at Walter Reed when she left there just before her vomiting spell that she had six weeks to live, but she took that six weeks as an absolute maximum. She kept saying, "It won't be six weeks. I'm going to die next week," things like that. And she would say this until everyone got lined up properly--her family became properly concerned over her dying. I didn't get much hostility from her from then on, yet there had been a time some three months before when she had called me up at 4 in the morning and said, "How does it feel to be waked up at 4 o'clock in the morning, doctor?" She hung up but in half an hour she called me up again and was crying for about 35 minutes. I didn't say anything except to grunt now and then to let her know I was there, and she said, "I can't stand it," or something like that. I said, "I'm still listening," and she stopped and gulped and just realized that this was really something--that I listened to her. This was one of the biggest impressions on both of us in these last three months.

Now she was in bed in her own home, the home her husband had bought for her--just what she wanted, and she was all tickled about it. She called me to tell me how tickled she was, and said she sat on a bench in the kitchen looking out the window at the squirrels and everything. Then she would call and she would be in bed, and she would say, "I want you to come and visit me. Can you possibly do it?" At first I put her off but about a week later I went to see her. It was the first time I ever saw her outside the office or hospital. She was in bed and was kind of happy. She said, "I must say, everything is so wonderful. There is a glow of love around me. My husband is here and my daughter isn't in boarding school any more. She lives at home and will live at home until I die. Then she's going back to school. My mother is here and sister is here, and every once in a while a friend drops in. Yesterday a member of my old therapy group came to see me. Everything is wonderful." Yet only two or three weeks before this she had complained that "that dadgummed sister and mother and husband had gone and bought her a plot of ground to be buried in and were just irritating her to death over it."

After this, however, in her daily phone calls she seemed to be in great peace and everybody was just waiting on her and everything was just wonderful. "But you know," she said, "Mother still tries to control everything. She still tries to interpose herself between my sister and me. I used to hate my sister. I used to think she was a selfish person, but we've had long talks now and it just isn't so.

She has had psychotherapy and that doctor has done wonders for her. She is much changed. The main thing is that she and I know what we feel, and Mother tries so hard to get herself in between us again but we just don't buy it." She forgot she told me this, and she told me again on other days. She said, "I don't remember too well now what I say and I might tell you things two or three times." I visited her again, sitting next to her bed, and was alone with her there. It was a very bright room. She was kind of clumsy with her hands a little. She didn't have any pain at the time. She said she had some pain once in a while during the day, maybe for an hour or two, and she wasn't taking any regular shots. She would take shots for a couple of days, then she would skip a couple of days. She sort of took care of herself by putting her head in the right position or sitting upright long enough. This was important to her and seemed to straighten things out in her feelings. Also she would ask someone to do something for her. This was sort of magic in a way. It would take care of the pain whenever there was any. So this time as I was sitting there, I said, "Look, you're in the bed. You don't have to be in the bed. See, you're moving around, wiggling around like a child. You wouldn't have to stay in bed and become stiff and weak like you seem to think. If the world's heavyweight boxing champ stayed in bed like this for two months I could lick him myself. If you get up and move around you'll be strong like you ought to be. The way to do it is to sit up a while, and when you feel a little weak get back in bed. Have your husband push you outside in the air a bit. Do a little bit and you will keep your strength up." Now, I thought at that time that I didn't want her to die, and I thought I was probably making her have a show of being alive when really she was moribund, and I was only fooling myself. Nevertheless, she took it very enthusiastically and she got out of bed, got into the wheel chair and went around the house that very moment. Then she got to vomiting and she had to get back into bed again. She got up again a little bit later and was up for about an hour. Finally she got back in bed and I went home, and I thought, "Now what on earth was I really doing?" I formulated an opinion that this is what had happened:

This woman had at last reached success in her life. This is what she had always wanted. Maybe she had had it when she was one year old or before there was a sister, and now it had happened to her again. The family had established what seemed to be her glide path. She and they were trying to end her life mission on that runway six weeks distant. Occasionally they would pull up for higher altitude, trying to lengthen the glide path, you see, as if they were saying, "We can't learn how to land in six weeks. We'll learn how in six months. At this rate we're going in too fast, so we're going to pull up." But then she would start vomiting and they would say, "Gee, she might die in a couple of days and we have all this talking and caring for her and for each other that we haven't done yet." They would just crowd around and be very solicitous. So it seemed to me as if they had a headwind or something, and they had to get the airplane down and then drop the flaps and get down quicker. Now if they really had this kind of contract they were committing euthanasia. I didn't want to commit euthanasia. I wanted to keep the patient alive to the last minute, alive as long as possible, just any kind of life, and in the last minute science might discover something that would cure her.

Yet, I think I had never seen anybody so successful in mid-life as this woman was at the end of it. She had everything. She had everything she always wanted, and she knew she was going to have it better tomorrow than today. She had

everything to look forward to. And you and I, we will have uncertain lives. Tomorrow we can get drunk and kind of evade life but then the next day we're going to have to go to work. That's how it goes, and we can't do what she was doing. I think I was envious and I think I didn't like her to do that. I think that was part of it, anyway. That's why I would say, "Get out of the bed and stop being so blooming dependent." I had often tried to do this with her and with other patients. This is appropriate to do when the patient is not dying, but she had it made. The family had a contract which they could fulfill. They knew how to do it--psychological euthanasia. And now I was coming in here and saying, "You're going to live," but it was for my own reasons--my own attachment to her and my envy of her dying. Well, actually I felt sorrow for her, and maybe compassion. You remember in the books, you are supposed to assume the patient is not going to die, and in a way I assumed she wasn't going to die and talked as if the future existed. But she assumed she was going to die. It was a well worked-out contract, it was what she wanted, and I had the feeling that if this woman didn't die in six weeks, or if somebody discovered a cure that would make her live for years she would be disappointed, and so would the family and they would have a big problem to work out.

I visited her for the last time. She was quite a bit weaker. She could hardly pick up anything, and she really looked a little weird. The week before she didn't look weird at all. She looked the way she had always looked. Now she was rather drawn looking and exophthalmic and pale. This time I played into what the family had done. I didn't oppose them. I didn't say, "Get out of bed," and all that stuff. I just talked with her normally about what people were reading to her, talked about her feelings about people. I was only there 20 minutes when she said, "Well, goodbye, I feel a little weak. You go." Then she died two days later. She died at home in her sleep, which anyone could have predicted, exactly the time when her death was predicted. The night before she died she was talking with the family around her.

Question:

I wonder why she had so little pain, when we know that she had bone, brain, and lung metastases for a long time.

Answer:

Well, it seems that the amount of opiate or drug to kill pain depends on the social situation you are in. If you are surrounded by a lot of howling people or people who don't like you, it will take a mighty lot of opiate to keep you out of pain, but if you have everything you want, regulated the way you want it, and not only the way you think you want it but the way that's good for you in the situation, then you may not need any opiate. Now this seemed sort of fantastic to me. It still does a little. But it seems to me that this is something on the order of what happened, and maybe the most fantastic part is that maybe I was envious of her. She was getting what we all want for ourselves. Maybe sometimes we would like to see sick people have a little pain so that they can deserve the care that they get. I'm not sure of this, but it seems fitting, anyway, with the other feelings.

Question: Is that why you were mad at her?

Answer:

No, the first time when I told her, "I'm mad at you.." I was angry because she was taking herself away from me, taking her personality. Of course, it now has a second meaning: I was mad because she, and not I, was staging all that long dying scene. Anyway, when I told her I was mad at her for dying, she said, "Oh, I'm so glad you're mad."

Since then I have noticed other times when people had a sort of contract to be mentally ill. A family or a group or a community agrees that an individual must have certain symptoms, and so the individual develops them. Yesterday, after you left, a patient, M.K., said, "My mother and my brother and me used to have big troubles together, and my mother would say, 'One of us is going to go crazy,' and the way she told it, by golly, it was just about that! When one of us did go crazy it did relieve the whole business. We could all say, 'Well, she's crazy,' and we would take care of her and there was no longer a big strain." Well, there are other patients we have that I have thought back on, and this sort of contract fits in many ways. You know, we always talk about the fact that the responsible men in the Army, whether they are master sergeants or colonels, they can't go crazy, you know, so each one gets his wife to go crazy for him and she comes into treatment and he stays away from treatment. This is a minor contract, a contract for a neurosis usually, but it's a social contract, and certainly what Mrs. R. was doing seemed very vividly to me a form of social contract. It rubbed me the wrong way at first, when I realized what was going on. Then I saw that this is culturally appropriate if we do it right.

It seems that we do very badly with people who are dying when we take them out of the home. We are no longer able to handle them so everybody else wants to get in bed and die maybe, or something like this, but they don't let the patient regress, they slam her in a hospital bed, visit her a 7 o'clock, and all day long she has a relationship with the hypodermic needle. The nurse comes in and gives her a shot, then the patient hollers some more and they give her another shot.

Question:

Was there some special difficulty between her and the hospital staff that made them part company so easily?

Answer:

Well, she was harder to get along with than the average person. She was more perceptive and was stingingly critical. She either kept herself active with forceful demands or she remained morose and sad and forlorn in the hard cold hospital--where we don't let nurses nurse anyway. The nurses are medicine-givers and the doctors mostly make rounds and decide what the medicine-givers shall give.

Question:

With so few staff and so many very sick patients for 24 hours a day, the hospital from a human point of view fights a losing battle anyway, doesn't it?

Answer:

The hospital often tries to do for the patient what the family should be doing.

Question:

But patients seemed resigned to whatever hospital management they get. They even show gratitude.

Answer:

Yes, even in the worst hospital they'll often say, "They treat me so well." It may not be as good as a home would have been but for them it is pretty good, I guess.

Question:

She had a peaceful death and a stormy life, where most people have the opposite. Did she have a great reaction that was obvious, about her death? Was there ever any grief attached?

Answer:

A little, maybe, but it wasn't what I'd expect. I think at first she felt bad and just busted up because of it. She was worried and upset. Then she got on to this worrying about her daughter. She had great, unrealistic, crazy plans for her daughter--after she herself was dead. But then she got on this track, this glide path I was talking about, and there was no grief, no crazy plans. Just peaches--great love for everything.

Question: (inaudible)

Answer:

Well, you see, I'm trying to get an intuitive feel about what's going on in our culture. I think in looking back at the alcoholics I have known, many of them would like to have a dramatic case of leukemia. "I just want to die. Nobody loves me," etc. This is a popular thing to have--leukemia--and next to that, some other kind of cancer.

Nobody is going to die of tuberculosis nowadays, but in the days of La Traviata, tuberculosis was the romantic thing to have. Nowadays, you've got to have cancer if you are really going to die importantly. Cancer nobody can do anything about! Leukemia seems the most important. Cancer of the breast or cancer of the prostate is O.K. but some other kinds are probably not too good. Cancer of the eye, for instance. I'm serious about this! This is real. I'm trying to figure out what's in fashion for the times. I hear it in the patients, the attitude they have toward disease. What's a popular disease to have?

Question: Well, what about heart attacks?

Answer:

Yes, that's great for big executives or something but it doesn't have the martyrdom to it that cancer has. I think it's about a fourth rate way of dying. That's like driving a Chevrolet instead of a Cadillac.

Question: What did you feel about going to her house?

Answer:

It felt quite appropriate to me. Maybe it really wasn't but I felt it was. I learned a lot--seeing the family's taste...the kind of food they ate, the way they showed off some objects, cared for some, let others go dusty, unrepaired, unpolished. I got a feel for the sort of obstacle course of furniture and stuff you had to pass through in order to walk the length of the house. I saw the traces of little family habits in bathroom and kitchen--the way they managed dirt, ablutions, and other little rituals. These are things the patient can't tell you in an office, any more than he can tell you over the phone what his countenance looks like. These things are not fully available to the patient's consciousness. I saw her sister in that house and she was quite personable, not a monster at all, which I had thought she was from listening to the patient.

Question:

I'm thinking in terms of the fact that this is an unusual situation in psychiatry--to have a long-term patient who died in a slow way. And I think I would have a lot of feeling both ways about going in. It seems to me if you go to her house, at that point you are not going as a psychiatrist.

Answer:

If I'm not a psychiatrist, then what am I? Maybe I'm a psychiatrist acting like a doctor. I think, though, that I did go as a psychiatrist.

Question:

Well, maybe you were called in on a psychiatric consultation, but it seems to me you went to her house not to make her improve psychiatrically but maybe as a friend.

Answer: Well, can't a psychiatrist be a friend?

Question:

I'm talking in terms of a professional role. I don't think he goes in and says, "Tell me about your feelings." I think he goes in on the basis of "I've known you for a long time..." I'm not saying he couldn't; I'm saying he wouldn't. Actually, I'm not saying--I'm asking you.

Answer:

Well, she and I would talk about feeling a little because it seemed to me I was the only person left she could be angry at. I think you're saying, when you

talk about feeling, "What did you do next? etc." but I don't think a psychiatrist always talks and listens about feelings. This is only one way to do therapy. There are many methods of therapy and I think you may be therapeutic when you just go to the home.

Question:

I am thinking that this action of going to her house, though it might not be criticized openly by other psychiatrists, I think that somebody might say, "What was going on at the end of her hour?" "What's the kind of transference behind it?"

Answer:

In analysis, you can treat only with transference. That's your only hold on the psyche of the patient, and you only have sensitivity to that transference with regard to your own feelings. I think here we are dealing with a larger block of life than can be dealt with in the analytic interview.

Frank Lloyd Wright once said there shouldn't be such a definite wall between the living room and the trees outside, that you should pass onto a porch, then onto flagstones out into the grass, then to the shrubbery--there should be a sort of transition. You don't need narrow channels and thresholds. I think psychiatry can be like that. Some analysts don't say a word. They are just doors, I guess. All analysts are not that way. I think there are analysts who go to see patients.

Question: But it's inappropriate to go to the patient's house?

Answer:

Maybe so. I think I felt guilty about my part in the "euthanasia" scene being staged at home by the family. Once when she told me she had four more weeks to live I said to her that however long or short she lived I would still be the same person with her. At least, this is what I claimed... In a way, she kept saying to me, "Give me the glow of love" (which she finally got), or else, "Give me hostility."

Revised 1977

PROVERBS--their use in individual and group evaluation.

MATTHEW D. PARRISH - FT. BELVOIR April 1960

PROLEGOMENON: Brain injured, senile or retarded or mildly psychotic patients can often make a very good social impression, even carry off an entire interview, as long as they can keep the situation familiar. The interpretation of proverbs is one way to provide a controllable but unfamiliar stress.[1]

The following shows their use in a mental hygiene service.

I. Individual Interviewing: When the interviewer asks a patient to interpret a proverb he may expect it to reveal:

(1) The ability of the patient to form abstract concepts. Example: "a rolling stone gathers no moss", when interpreted abstractly and generally may mean "a vagabond never gathers any material goods" -- interpreted correctly: "stones which always roll around a lot never have a chance for moss to gather on them". When this concrete-thinking patient is pressed to interpret the proverb with reference to people and to life in general, instead of just to stones and moss, he may say.."If I walked out there on those terraces, no moss and grass would stick to my shoe". The concrete interpretation may occur in any impairment of thought which tends to narrow the patient's horizon of perception and his resourcefulness. Thus in panic, brain damage, schizophrenia, or at tender age; his accessible store of associations which are appropriate to the interview situation may be very limited.

(2) The vividness and completeness of the patient's conceptions is revealed. The patient may go beyond the average abstraction and generalization and show poetically intuitive thinking. Example: In interpreting "The toad plans to eat the wild goose's flesh", the patient may bring the interviewer to a clear emotional understanding concerning the ridiculous but self-assured calculation of certain almost helpless dolts aspiring to overreach the free flying, highly endowed artist who sweeps along oblivious to them. The patient here may present in a picturesque manner the humor, the pity, and the quiet conformity to nature in this proverb. Seeing the proverb with poetic feeling may indicate a somewhat higher order of thinking than a mere intellectual abstraction or generalization. If the shock of feeling produced by the proverb however, is too intense or bizarre, this may indicate pathological thinking.

IV. List of Proverbs: One can collect proverbs from proverb books[2] language texts and hearsay. The following is a list of rather hard proverbs familiar to few patients. Remember that almost all proverbs admit of more than one abstract interpretation.

1. The farther into the woods you go, the more trees there are.
2. One hand washes the other, both wash the face.
3. One dog barks and a hundred bark at the sound.
4. God has hands of wool and feet of lead.
5. A dog can only dream of bones.
6. You can't catch two frogs with one hand.
7. To covered milk, no flies.
8. It is darkest below the lighthouse.
9. A bird can roost only on one branch.
10. Meat on a block can be chopped any way you like.

NOTES:

(1) An exposition of the clinical use of proverbs:
Elmore, C. M. and Gorham, D. R., Measuring the impairment of the abstracting function with the proverbs tests.
J. Clin. Psychol 13, pp. 263-266 July 1957

(2) A classical source is Henry Davidoff, A World Treasury of Proverbs from 25 Languages, London, Cassell 1961

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MATTHEW D. PARRISH April 1960

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(3) The patient may project into the proverb his concept of himself and his own life. Thus, a patient who feels oppressed may interpret nearly everything in terms of struggle with a superior. Example: The rolling stone may have the connotation of an outcast son. The toad may be a worker oppressed by his boss.

(4) The proverb may reveal the ability of the patient to "shift gears" in his thinking to see the problem in a new frame of reference. Example: After the "rolling stone" is interpreted abstractly as in (1) the interviewer may ask for a completely different interpretation with regard to people or life. The patient then may say "a man who keeps himself busy never stagnates". Note that the different interpretation is still an abstract one. If the patient merely reverts to the concrete way of thinking there is no "shifting of gears".

(5) The proverb may reveal the patient's emotional reaction when faced with a problem that he can not solve. Example: He may be asked a very hard proverb, or he may be asked to give a third completely different interpretation for "a rolling stone", --whereupon he may (a) blithely give the same old interpretation in slightly altered form and refuse to see that he has done no more than this. (b) get angry. (c) stammer and sweat. (d) give excuses. (e) give up with indifference.....

II. Group Interaction: When presented to a group for interpretation a proverb will provide some or all of the above information and in addition it will show:

(1) The ability of the group as a whole to collaborate on a solution.

(2) The ability of the individual patient to join the group either in productive effort, or in a supportive attitude towards the "brains" of the group, or in leading the group away from a solution, etc.

(3) The methods the individual uses to handle his anxiety in a group (humor, sweat-it-out, wait for the word from the leaders, etc).

(4) The group's influence on the individual. For example..the group may prevent him from "shifting gears".

III. Statistical Data on Interpretation of One Proverb: One hundred consecutive soldiers being screened for Army Pilot Training were asked to interpret individually the proverb "a rolling stone gathers no moss". Twenty-nine percent interpreted the proverb only in the general sense that a "vagabond never gets rich, or the converse-that if one settles down he will gain friends, etc." Thirty-three percent interpreted the proverb only in the sense "that a busy man never stagnates, etc.". Thirty-three percent could "shift gears", and interpret the proverb both ways. Two percent could only interpret the proverb concretely.

10/12/73

COMMENTS ON MAN AND TECHNICS, by Oswald Spengler, N.Y.: Knopf, 1932, or Der Mensch und die Technik, C. H. Deck'sche Verlagsbuchhandlung, Munich, 1931.

By M. D. Parrish

p. 6, "Achievements of humanity" means amusement-making and sparing of human labor, with lack of concern for the soul. The soul = the abstract essence of the culture reflected microcosmically in the individual member of the culture--the pattern of the culture's thought and behavior reflected in the pattern of the individual's thought and behavior. (--what you, the spirit of the ages call is nothing but the spirit of you all, wherein the ages are reflected--Faust 11. 577-579.)

p. 12, "Mankind" means the white races, or more exactly, the inhabitants of their great cities, or more exactly still, the "educated" among them--the intellectually and verbally expressive.

p. 15, Destiny of an individual = being born into a particular country, a particular people, a particular region and class within a certain world-history. "There are no men-in-themselves, such as the philosophers talk about, but only men of a time, of a locality, of a race, of a personal past, who contend in battle with a given world and win through or fail, while the universe moves slowly on with a godlike unconcern."

p. 19-26. Man is by nature a beast of prey. Therefore, with perspective-seeing eyes that command space and fix upon a target. He is highly mobile, combative and clever. The opposite type--a cow or elephant--keeps his character in captivity. But big-city man becomes in some respects a cow, domesticated, loving comfort, and therefore a prey to the more cleverly active races, though there is a dog-eat-dog life in the great city.

p. 38. "As the implements took form from the shape of the hand, so also the hand from the shape of the tool... It is impossible that the formed hand was active even for a short time without the implement."

p. 40. The eye seeks out the connection, the cause and effect, the truth. The hand works out the connection of means and end. It works simultaneously with means and end, and with facts.

p. 41. "The act of the thinking hand we call a deed."

p. 56. Speech appeared rather suddenly. Speech is never a monologue. It is intended as conversation. "All speech was of a practical nature and proceeded from the 'thought of the hand.'" (Later it became speech of the eye--of truth and cause and effect, and of soliloquy.)

p. 56. Speech equilibrates with enterprise as hand equilibrates with implement. Both developed together, each forming the other.

p. 58. "Collective enterprise produces social thought." "Collective doing is as effectively a unit as if it were the doing of some single giant." The success of collective doing leads man to give up the more ineffective freedom and individuality. Hence, he develops language and collective styles of behavior and of belief.

p. 59. "Man has become the slave of his thought."

p. 68. Political life produces power, economic life produces booty. Combative subjugation or subordination is natural and is the normal method of human progress. In primitive life, where techniques are poor, individual life measures but little. In every (Icelandic) sea voyage only a part of the ships reached port. Whole tribes died of famine, but (p. 64) "the numbers decreased rapidly, but what was felt as annihilation was not the loss of one, or even of many, but the extinction of the organization of the 'we.' The individual disappears into the greater numbers of the wealthy tribes and into the house"--that is, into the family.

p. 70. "It is precisely mankind's best specimens that know least of quiet, happiness, or enjoyment."

p. 71. "The idea of personality in its dark beginnings is a protest against humanity in the mass, and the tension between these grows and grows to its tragic finale." The group leaders remain small. There is increase of hands, not of heads. The ever small pack of the gifted dispose of (manage) the increasing herd.

p. 72. "The ego hates only his peers, envies none, despises many," and is envied by many. The wish of the subordinate is not to destroy the superior but to destroy some subordinate--even to destroy himself as a subordinate, thus becoming a superior by means of ruling some subordinates. The individual does not struggle against power. He struggles to become power. He struggles against society (cf. Freud). But the individual who can see the actuality of his being created by the confluence of group forces and behaviors can step beyond such a position. If another culture, different from that of the past, develops from people meeting the challenge of a certain landscape, then the people can rise to no higher complexity than the past people. But if people build a new culture by meeting the challenge of a complex set of artifacts and varied landscapes (moon, space), then a new height develops.

p. 79. On the one hand, warriers (nobles, lawyers, politicians); on the other, priests (doctors, teachers, journalists). On the one hand, facts; on the other, truth. On the one hand, destiny; on the other, causality. On the one hand, intellect as servant of strong life; on the other, intellect as subjugation of living. Inventors invent for the fun of it, regardless of the consequences to other people or ultimately to themselves. The set of inventors and scientists and entrepreneurs thus proceed they know not where. They must only proceed. The individual laborers often see work as irritating and do not see the purpose of a business enterprise as a whole. They see the relation of the pressroom to their house and their place of recreation. "Men no longer see... that leaders' work is the harder work, and that their own life depends on its success: they merely sense that this work is making its doers happy...and that is why they hate them."

p. 81. Vikings reach Spain in 796, inner Russia in 859, Iceland and Morocco in 861, then Provence and Rome. The Black Sea, Kiev, and Constantinople in 866. The Caspian in 880, Persia in 900, Greenland in 980, North America in 1000. From Constantinople they set themselves up in Greece and Asia Minor in 1034. From Normandy they set themselves up in Sicily and Lower Italy in 1029, in England in 1066.

p. 91. "As once the microcosm Man against Nature, so now the microcosm Machine is revolting against Nordic man."

p. 98. The masses are revolting against the role the machine has earmarked for them. But they can't conceive of machine-ness as a reality or a force—they think only the possessors of the machine are a force. But if each worker possessed his own machine he would still be more and more enslaved to it as the style of living by the machine progressed. The economic value of every real personality in technics leadership has become so great the masses can't comprehend it, can see no reason for it. In the machine world the individual is now entirely without significance. "Only numbers matter."

p. 101-102. The center of gravity of the industrial world is moving toward the colored races and the underdeveloped world. The white men gave the industrial secrets to Japan, Malaya, etc. WW I really resulted in the rise of the worker. WWII really resulted in the rise of the colored peoples. To the world, though, the American Negro is a white man.

p. 103. For Faustian man, the Faustian technics are an inward necessity. "Navigare necesse est, vivere non est necesse." For the colored peoples these technics are but weapons against Faustian man. The technics will be discarded when the fight is over. The technics will end when Faustian civilization ends.

p. 104. "Optimism is cowardice," —optimism concerning the future of the West—because it prevents us from living the remaining fight. We only give up now and tell ourselves there is no need to fight, as indeed there is not if we say so, for at that point Faust is dead.

SYMPOSIUM ON GROUP PSYCHOTHERAPY *

WALTER REED GENERAL HOSPITAL

(Remarks of LTC Matthew D. Parrish, 30 November 1961)

Well, I guess some people think of group therapy as a child of necessity; they hope to treat six people at a time--48 patients a day instead of only 8. But the group therapist is not just treating 48 patients, he tries to get hold of a social system--to see how it works, to help it to change. Therefore, if he has six debt addicts in a group, he will frequently get their six wives into a group--maybe combined into the same group, maybe not. The group will very likely meet in the evening; it will meet for one-and-a-half-hour sessions instead of for 50-minute hours; there will be two therapists instead of one; the two therapists will spend perhaps an hour discussing the session after it is over; they may make visits to the community, to the stores that sell to the debtors, etc. Group therapy is often very direct; it takes the problem quickly in hand, but it is not necessarily convenient nor time saving.

You see, the approach of a therapist to the group may be quite different from his approach to the individual; as an individual therapist he may squeeze the patient into the mold of the analytic model or the organic-genetic model (anyone can be squeezed into any model and therapy will still go on). In that sort of treatment the assumption is that the individual is a self-contained, complete organism and that several of these organisms together would make a group.

The true group therapist, on the other hand, sees the group mind as coming into being before the individual mind. Certainly each of us was born into a social world which was dominated by the mind of the Western Culture. From this mind we derived language habits and patterns of thinking. We could not possibly choose to think without verbs--without agents of action and without objects of action--though some languages think this way. No, we simply interacted with this group mind that we found in our world and we derived a certain way of thinking which was itself a part of that group mind. We began to fulfill certain roles for the group. Did any of us bring with us fully-developed individual roles or ways of thinking which we forced the group mind to accept? No, we were born at a certain time in a certain family position with certain hereditary shape and appearance. Because of this we were pretty much forced to adopt a particular role in the group. If one of us, here, with his same heredity and the same neonatal desires and instincts had been born the fifth child in a Hottentot family in 1877, he would have become quite a different individual from what he is now. How little choice we have!

Now it is obvious that the group mind has tremendous influence on the child. But it also continues to have tremendous influence on the adult; minute by minute he adjusts his so-called individual thinking, his language, and his desire in accord with the feedback he gets from the groups where he plays his roles in daily life. A patient may, of course, identify himself

* Extracted from Symposium on Group Psychotherapy, 30 Nov. 1961. A report published at WRGH by Theodore McB. Badgley

of the world around me and I began to see it in the groups we treated. As co-therapist we first took a group of 30 ex-psychotics; we lectured to them, tried to get them to interact, didn't get very far. After awhile I was transferred to the women's ward; there the group was more interesting, they were much more emotionally expressive in that group. I began to try all sorts of things; once I played a record and let them free associate to it in turn so each member saw how the other person was able to feel about this. Later I played the same record to other groups, sort of standardized the responses like a Rorschach. We varied the meeting places of the group and this had an effect on what the group was able to do; it made quite a difference whether the group was in a small room tightly packed, or in a large room scattered along the walls.

Well then, I went down to the SCO and told them I wanted to go to Austria, second choice, Germany; so they sent me to Korea. I tried to get groups together over there but people came and went so fast it was hard. Finally I got to a big clinic in Yokohama. There we had groups of outpatients; again women in groups were more reactive emotionally than men--they would cry or cuss each other out, or stalk out, and the others would run after them and bring them back.

Later I came to Fort Belvoir where nobody had heard of group therapy. It was really a child guidance clinic but they played with children one at a time. Out of a sort of desperation I started a group all by myself in the back room. Sometimes so much noise came out of the room and the patients and I looked so interested when we emerged, that the staff began to come around and say, "Can I sit in and watch?" It was whitewashing a fence. Finally the staff caught the enthusiasm and they all started groups, every one of them. They were treating more groups than I was; so in working with them I really started learning. I learned the most managing sort of therapy from social workers. The psychologist introduced me to social psychology--to George Herbert Meade, for instance--and to some social group theories. But in actual therapeutic practice, it was the social workers who would sit down with me and give free range to their thoughts; we co-therapists had a way of getting together after a group session and "cooking something up" that in its first form would seem so crazy that if anyone outside knew we had such thoughts, they would have locked us up. But we would get it condensed into something we really wanted to use and would put it into practice. I suppose I had a dozen groups of my own at Belvoir. Some were limited to five sessions by contract from the beginning. Two of them ran for three years continuously, with people getting well and dropping out and others joining. Three of us went to the Washington School of Psychiatry and took a course in Group Therapy; we had worked together so much that we sort of dominated the class I am afraid. We also went to St Elizabeth's and studied some psychodrama--so that is my history as I think of it now.

There is one thing I want to say about history though, it is not just the facts of the past: it is the arrangement of those facts and some phantasies to fit the present. If you ask me my history tomorrow, I'll give it to you differently; or if I write it in a book, it will be still different.

The same is true of a patient's history; if you take a social history, you will get certain facts; then if you put the patient into effective therapy--group or individual--that history will change. Therapy changes history; a group in therapy will tell you the history of their meetings after say 20 sessions, but if after 10 more sessions they again tell the group's history, it will be different.

The history of countries changes in the same way. I am not talking about deliberate alterations of records like the Russians do, but the general narrative you will find in the textbooks over here, the thing that most people call their country's history. I have often thought that the best way to know the history of England is to read the Trojan War written by somebody back in early England, say Wycliff, and then read the same history written by some Englishman 50 years later, then another even later, and so on until 1961. You don't read a word about England; you only read about the Trojan War, but you learn the history of England, nevertheless, because you learn how they change all their ideas about the Trojan War. Some of the early writers give you the Trojan War as if it were a struggle to get Helen, and then they give you a lot of stuff about fate and the gods' feelings about men. Later historians give you the stuff about getting control of the Dardanelles and they think it is all an economic thing. Still later they say it is a war between different ideologies. Well now, the history changed according to the way the culture group of the patient group changed, and I rather think that the history of group psychotherapy may change too.

* * *

In any therapy, I think, we must assume that the patient's symptoms must have had their pre-treatment meaning only in relation to the normal group where he spends his daily life. When you change him by means of therapy in a private office, you disturb the equilibrium of his living group. The living groups actively help or hinder you; yet you see these groups only through the patient's eyes. To me this is like doing a physical exam on a patient's shadow.

How can you evaluate your patient's living group directly?--By bringing the whole family in for treatment as Carl Lauterbach and Bill Vogel do; or by going to the home for a couple of days and seeing the whole family in action as Ralph Morgan does; or by visiting the patient at his job as some of you occupational therapists are now doing; or by talking to his teachers, his commanders, his chaplain, his physician, or the health nurse for his neighborhood--as they do in many Mental Hygiene Services.

You all know a delinquent child is largely a symptom of something wrong with a community. There are whole communities with no delinquency; well, do you work with the child or with the community?

In these next papers I hope we may see therapists getting a grasp of the total organism out of which the symptoms grow--the total family or other community seen as a single organism, with many organs playing various roles and showing various symptoms.

In the field, the engineers and the infantry are so immediately concerned with social epidemiology that they support the Mental Hygiene Services as their psychiatric staff resource and they benefit quite well from squad therapy, unit consultation, NCO groups, etc. In a general hospital, however, we can hardly hope that an entire service will handle its community symptoms--its depressed, delinquent, or over-indebted people--by any such total means. For general hospitals too are organisms but they are rather isolated from the communities they serve. When under stress, a hospital tends to revert to the old, comfortable, one-to-one therapy, even where group therapy or community consultation would be more effective as a cure for an entire problem. Such a hospital can nevertheless maintain pilot studies and research projects which treat certain special social organisms, e.g., milieu wards, family therapy.

8/25/76

LEADERSHIP AND PSYCHOTHERAPY--FRED FIELDER'S CONCEPTS

By M. D. Parrish

Fred Fielder's Hypothesis at Group Effectiveness Research Lab, 907 South 6th Street, Champaign, Illinois, December 19, 1961.

People are divided into the following two classes:

(1) Some people have positive interpersonal relations. These people are affected by other people's anxiety. They see their least preferred co-worker as not a bad guy. They make good psychotherapists or counselors. They make poor leaders in a competitive or stressful mission. They perform no better in competition than they do singly "just for the record." They put personal relations and the dignity of individuals ahead of the mission of the group--or even of missions they have planned for themselves.

(2) Some people have non-positive interpersonal relations. They are unaffected by the anxiety of other people. They see their least preferred co-worker as a stinker. They don't care much for what other people think of them. They make poor psychotherapists or counselors. They perform best in competition. They make good leaders in competitive missions. They put their mission ahead of their interpersonal relations.

(Anecdotally, it seems that) a few people function sometimes as (1) and sometimes as (2), but most people have consistently fallen into one of the two groups.

This hypothesis and its confirming data are set forth in Fred Fiedler: "The Nature of Teamwork", Discovery (a British journal), February, 1962.

Concerning psychotherapy, various schools of psychiatry agree closely on what is the ideal therapeutic relationship. They believe in (1) free communication between therapist and patient. (2) They believe in the therapist's accepting the client in a non-hostile manner. Therapeutic effectiveness has little to do with the particular school of psychotherapy. This is brought out in the following reports:

Fred Fiedler: An Investigation into the Concept of Ideal Therapeutic Relationship. Journal of Consulting Psychology, 14: 239-249, 1950.

_____: An Investigation into the Analytic, Non-Directive, and Adlerian Therapeutic Relationships. Journal of Consulting Psychology, 14: 436-495, 1950.

_____: Factor Analysis of Analytic, Non Directive, and Adlerian Therapeutic Relationships. Journal of Consulting Psychology, 14 (?), No. 1, pp. 32-38, 1951. (?)

Some random examples:

Poor Therapists--probably to reassure themselves of their own superiority or "adjustment"--see the client as different and strange.

Fred Fiedler's Notions of Leadership and Psychotherapy 8/25/76

An offender usually concentrates on one way to be maladjusted. Thus disciplinary offenses, sick call rates, visits to counselors, or school grades are uncorrelated indices of maladjustment.

Group members who saw their fellows as similar to themselves (or whose groups saw them as similar to other group members) had lower anxiety, higher grades, and lower sick call. They lived in adjustment with the group. But the aim here was to maintain group status quo. Probably a person seeing himself as different would be a better leader if the group were going to change. That is, he could better perform a creative mission.

--The solitary aspect of the pilot flies for love of flying itself, not for the group feeling of flying with the squadron. Accordingly, his relationship is with an abstract reference group--with God, with the world of nature, or with past history. This kind of pilot has internal difficulties, relieved by flying, and he cannot conceive of these difficulties as being a part of the feelings of his group.

The social aspect of the pilot, however, loves to fly as a way of doing a mission, together with others. This aspect may develop later in his life as a pilot. The group can set the mission and the ambition for him. The peer group can take the place of the abstract reference group, and the pilot can, by "transference," work out his original internal difficulties--can externalize and manipulate the difficulties within this new peer group. The pilot's original group--parents, siblings, and world of his youth--was a part of himself and was broken off. By flying he may seek re-establishment of that group, with himself as a member. The peer group becomes a part of himself now. That is, he becomes an organ in the group organism.

DISASTER--NOVA SCOTIA COAL MINE

(An Extract for use in Disaster Training)

By Maj. M.D. Parrish, OTSG Nov. 1961

Reference:

Beach, H. D., & Locus, R. A. (Eds), Dalhousie University, Nova Scotia. Individual and Group Behavior in a Coal Mine Disaster. Printing & Publication Office, National Academy of Science, Washington, D. C., National Research Council Publication 834 (1960)--Disaster Study No. 13, Disaster Research Group on Anthropology and Psychology.

At 8:05 p.m., October 23, 1958, there was a mass shift of underground material in a Nova Scotia coal mine--called a "bump" in the miners' parlance. There were 174 persons in the mine. Seventy-four were fatally injured, 100 were rescued. After the rescue the mining company stopped all mining in this community forever. The community population was 7,138. All were families. There were no transient workers. The majority were Anglo-Saxon Protestant. The slant depth of the mine was 14,200 feet at 30 degrees. The mine bottom was at 4,328 feet.

Small bumps had occurred every year for the past several years. There was an average of two dead in the mine every year from all causes. A 1956 explosion in the mine had produced a great deal of work involving many of the same persons as in the present disaster. Accordingly, the community was somewhat familiar with disaster.

When the "bump" was felt above ground, six miners above ground interpreted the bump correctly as a cavein. Five of these had relatives presently below ground. Six off-shift miners without relatives in the mine misinterpreted the bump. Fifteen of 17 wives whose husbands were in the mine interpreted correctly. One-half of 18 wives whose husbands were above ground interpreted correctly. Yet all townspeople were equally well oriented and experienced about bumps. It appeared, then, that direct personal involvement had more effect on interpretation than did prior experience.

Every person above ground sought confirmation for his interpretation from other people, no matter how sure he was of his interpretation.

Almost all off-shift miners reported to the mine for rescue work, even though this was very dangerous. It appeared that loyalty to the miner group superseded loyalty to family. But the family's loyalty was also to the miner group. The wife could not have held her head up in that society if her husband had not gone to rescue the other husbands.

The wives whose husbands were trapped below sought company (especially at night) in their "extended families" or in their neighborhoods. This aspect of disaster seems to produce a dependency group that makes people gregarious.

NEWS. Official information will suffice if it is accurate and plentiful enough, but if not plentiful enough or on the right subjects, then false news will be generated to fill the gap. (Hallucinations fill the gap in

an individual in those deprived instances where there is not enough sensory input the suit the emotional demand.)

Below the surface the injured men became emotional isolates from those who were not injured. They couldn't help in escape efforts. They were a drag on morale.

At first there was a p_ od of trying to escape. The trapped men dug in several directions for three days. Finally their lights burned out, they met with noxious gas, and with caveins.

There followed a period of trying to survive--three more days for a group of twelve men and five more days for another group of six men. Water and food were rationed now for the first time. About 80% of the men drank their own urine.

Leaders in the escape attempts (first three days) were usually senior miners. They were activists and maintained a sort of "sympathetic nervous system" for the group. The leaders in the survival period were men who from the first had maintained a more passive attitude toward escape. They amounted to a "para-sympathetic nervous system" for the group.

(While members were voicing despair there was always at least one member voicing hope--thus allowing the despair members to go further in their protestations while the hopeful one held the hope-responsibility for the whole group.)

Miners, before being trapped, anticipated they would personally go raving mad if trapped, but while actually trapped they never lost control. While trapped, they did think, however, that amputating a man's pinned arm would drive him mad uncontrollably. They refused to amputate also because if he then died they would be blamed.

The hallucinations experienced below ground were only visual. They included kaleidoscopic, flickering lights and spots. One man thought he could see the stacks of rubble and waste and the metal coal pans. All hallucinations occured after several days of total darkness. (The verbal sociability of the trapped group may have prevented auditory hallucinations.)

Study of initiations (acts by a single man which originate a sequence of social behavior): In the group of twelve men there were fewer initiators, though there were more initiations that couldn't be assigned to a definite person. (Activities of a large group are (1) depersonalized, and (2) a result of subgroup coalitions.) The group of six persons was more democratized and had more leadership by <u>each</u> person.

<u>Escape leaders</u>. (1) Direct the attacks on the problem. (2)Perceive problems as involving physical barriers, not interpersonal issues. (3) Recruit one or two lieutenants--not the whole group. (4) They are individualistic, aggressive, and outspoken. (5) They are not concerned about the good opinion of others. (6) They have no empathy nor any great

emotional control. (7) Their performance ability is better than their verbal ability.

Survival leaders. (In groups waiting for rescue): (1) Are sensitive to moods and needs of others. They are sympathetic when appropriate. (2) They avoid dissention. (3) They are intellectualizers. They use communication rather than action to satisfy group needs. (4) Their verbal ability is better than their performance. (5) They seek general good opinion from the group--not from only one or two people. (6) They perceive themselves as making an important contribution to the group.

DISASTER--TORNADO IN WORCESTER

(An Extract for use in Disaster Training)

By Maj. M. D. Parrish, OTSG Nov.1961

Reference:

Anthony F. C. Wallace (U. of Pa.), Disaster Study No. 3, Publication No. 392, National Academy of Sciences--National Research Council, Washington, D.C.(1956).

Phases of Disaster:

(1) Steady state--the normal city.

(2) Warning.

(3) Impact.

(4) Isolation--period when impact area goes it alone.

(5) Rescue--help from outside.

(6) Rehabilitation--attempt to restore the steady state (also where advantage may be taken to make quick social changes which have been needed before).

(7) Irreversible change.

On June 9, 1953, at 5:08 p.m., tornado first hit the edge of Worcester, Massachusetts. This town had a population of about 200,000. Good community morale. Good disaster services--police, fire, civil defense. The vortex was half a mile across and moved at 25 miles per hour, southeastward across the area.

Warning to people in the impact area occurred only a few minutes ahead of impact. About 30% of the people saw the funnel and recognized it--about four minutes before it hit them. Forty percent recognized that it was an emergency--more than a summer thunderstorm. Eight percent were warned by others, 20% had no warning until personally impacted. Fifty-five percent took some personal protective measure. The highest winds were at about 500 miles per hour.. The air pressure drop in the vortex was about 5 inches of mercury--two or three PSI.

Impact area within the city limits amounted to two square miles and included 1,800 dwellings and a population of 9,000, but many of these people were at work so less than 8,000 were present. Twenty-five percent of these sustained some injury, 56 persons were killed--22 men and 34 women. Five percent of the population (452 persons) sustained major injuries. Thirty percent of these had major cuts and bruises, 20% limb fractures, 15% skull fractures.

Patterns of behavior of the severly injured but conscious:

(1) Self-orientation--measured extent of own injuries, etc.

(2) Extricated self or called for help.
(3) Went toward help or toward more comfortable place.
(4) Helped own family.
(5) Subsided into apathy.

Patterns of behavior of those not seriously injured:

(1) Self-orientation (very easy).
(2) Personal extraction and minor first aid to self.
(3) Helped own family.
(4) Perceived extent of community damage.

Of those perceiving extent of community damage, one group showed the following behaviors:

(5) Vigorous but random rescue work over a large area.
(6) Felt extreme fatigue when community aid arrived.
(7) Returned to the care of their families.
(8) Sometimes took a second go at community aid, followed again by exhaustion and futility.

Of those perceiving extent of community damage, another group had the following behavior:

(9) Denied the extent of community damage after perceiving it, or denied the possibility that he could help community.
(10) Performed aimless tasks or dropped into apathy.
(11) Acted as a sightseer.

Thus, at fifteen minutes after impact, of those not seriously injured, two-thirds oriented themselves, cared for family, and began to help the community. One-third took no role outside of their own family.

There were *no* significant emergent leaders, because:

(1) The normal leaders of the impact city were functioning, and
(2) The time before rescue (just over 15 minutes) was so short that emergent leaders didn't develop well. Leaders in impact area were men who had chosen community-responsible positions as a vocation, such as physicians, clergy, etc. Thus the first leaders to act may be expected to be those who already occupy leadership status (providing the situation calls for their type of leadership). If not, their attempts will go unnoticed, and the community will notice whatever leaders are making sense in this stage of the program--cf. the "escape leaders" in mine disaster vs. the "survival leaders."

The police controlled the dispatching of all hospital ambulances in Worcester. (Hospitals abandoned the idea of bringing medicine to the site of the injuries. The community therefore further isolated the hospital from both homes and streets, and let the police take care of the problems "in situ.") About 1,600 persons required some medical care.

Hospitals: 374 patients were admitted to the hospital out of 804 patients who came to the hospital. 87% of the patients were handled

in three hospitals, though 11 hospitals were available.

(1) There was more wound-shock at the hospital than at the site of injury. Patients were "infected" with shock by transport and by the attitude of the helpers. There was almost no blood plasma or blood expander given, though many blood donors appeared later. There was almost no tetanus toxoid given.

(2) Many contaminated open wounds were sutured immediately after cleaning, thus leading to many infections.

(The psychiatrist's armamentarium should include work therapy. Accordingly, he must have knowledge, through police, public administration, industry, etc., of the kinds of work available.)

Rehabilitation and repair of the city tended to revert the damaged area back to its former system of life and building, rather than to a less vulnerable one. (The people reassured themselves with the familiar. They took vengeance on the storm by rebuilding the same structures the storm had destroyed--so it could be destroyed again, perhaps.) This is the syndrome of rebuild-the-village-on-the-side-of-the-volcano.

(Pain was notably absent in both severe and minor injuries. Pain usually occurred when the social situation changed. That is, when the danger of further injury was relieved, when injury was being cared for, when excitement was over, and when normal life prevailed. Pain thus is a social phenomenon. The central nervous system of an individual is interconnected by means of motor and sensory organs, with the messages and events of the social environment, so that what an individual can become conscious of is regulated not only by what pathways are open in his own central nervous system but by the fact that his nervous system is an integral part of a social nervous system which controls the function of the connections within his own body.) (page 109-151) (See also MDP: The Social Nervous System and David McK Rioch: "Communications in the Laboratory and Communication in the Clinic" Psychiatry 26:209-221, August, 1963.)

Behavior in the Disaster Syndrome

Disaster is here defined as the disruption of the familiar world of the group. An individual may, of course, be greatly impaired and perhaps panicked by the sudden disruption of his own individual world so that he faces a completely unfamiliar situation. For instance, a "stroke" may render a man unable to speak intelligibly or to understand the language of other people. While this is a great problem, it is not a disaster if he is surrounded by a society which functions well and can carry him along in its routines of living. The intensity of disaster depends upon the extent of the group which is disrupted. If a city is disrupted but is surrounded by a competent hinterland it is not so much a disaster as if a whole continent is disrupted, so that there is no unaffected part of society which can effect rescue or can remain a model for the rebuilding of the affected society.

Disasters for most communities can be divided into three periods:

1. Isolation period. Many people are dazed, apathetic, and don't grasp the extent or significance of the destruction. Pain and strong emotion is typically absent or is sometimes inappropriately expressed. This is sometimes called the stage of random movement.

2. Rescue period. Organized people from outside the impact area can get many survivors to work effectively. Survivors are typically docile in this stage. Survivors in hospitals however tend to remain dazed longer or to go into wound-shock. This is sometimes called the stage of suggestibility.

3. Rehabilitation period. For about ten days the impacted persons are mildly euphoric--especially when they are still receiving evidence of mass care. There is an altruistic willingness to work for the community. There is a strong "we" felling among the survivors in the impact area. They are reluctant to apply for aid. They accept it only if offered. They are ambivalent about the offered care and they complain of the coldness and inhumanity of the mass care organization. This is sometimes call the stage of euphoria.

Counter-Disaster Syndrome

This syndrome occurs in people not hit by the impact but who have emotional ties to the impacted community.

1. These people manifest a guilt which produces over-conscientiousness about helping.

2. This over-conscientiousness results in part from the opportunity to escape from their own trouble.

The symptoms of this syndrome are shortness of breath, rapid heart beat, sweating, over-exertion, which produces fatigue. The fatigue also results from the great energy employed to maintain internal tension. The worker prefers to work on his own, without dependence on authority. His work may be quite hasty. Doctors frequently suture contaminated wounds. Under stress, any professionals may revert to familiar rituals which are not appropriate to the situation. Psychiatrists, for instance, may closet themselves with individual persons disturbed by the disaster, and deliver a sort of one-to-one therapy which calms the psychiatrist but renders him ineffective to society as a whole. Many of the obnoxious "sight-seers" really have the idea that they want to help (because of the guilt mentioned above).

Later these counter-disaster workers of the impacted community seek proof of the adequacy of their rescue efforts--because of the guilt they feel from not being severely injured. They are disturbed by the cool work of the obviously guiltless Red Cross and out-of-town people over the "possession of the disaster." They are also squabbles between local agencies over the privilege of giving help. This becomes especially destructive when materials such as food, fuel, blankets, etc. are in short supply, because agencies compete for the privilege of

contributing the goodies.

Mental Breakdown

There is no real mental breakdown among the impacted citizens. They only manifest apathy and other temporary disturbances, with some residual "phobia" for tornadoes, or bombs, or whatever caused their problem. Even notoriously unstable people remain undisturbed. The disaster syndrome produces very little guilt or conflict. It produces mainly regression, and then restitution.

The non-impacted survivors in the disaster area, however, have a counter-disaster syndrome. They have a guilt and therefore a conflict, which can lead to symptoms of mental breakdown. In the Worcester tornado, only two people were admitted to the mental hospital. Both were not directly involved in the impact, but they had family members who were involved.

Remember, that impact sets off some self-worsening events, such as bleeding, escaping gas, fires, electric lines down, people pinned under debris, people exposed to cold... After impact is over, injuries continue to increase until isolation is over. That is, until rescue begins or the injured begin to care for each other adequately.

Cornucopia Theory

There is a theory rather vaguely held in America that disaster will always be in a circumscribed area. The disaster area will be blanketed with goodies from an untouched cornucopia of supply outside this area. There will be no other disasters nearby to compete with ours. For a time, then, we will be the most important area in the world. Blanketing an area with an excess of goodies is considered better than a few well-executed works.

The dangers of this theory are that people plan repair rather than prevention. Organizations count on an excess of supply rather than on inadequate supply. We don't know how to do primitive medicine in rescue work.

Remember that the "Worcester tornado" actually began in Petersham and swept for one hour through Massachusetts, without any of the general population being warned to take cover. Partly this was because there was no tradition of tornadoes in Massachusetts. (Tornadoes are supposed to occur in Kansas.) Actually tornadoes are not infrequent in New England but people are less controlled by actual data than they are by their habits of thinking. Many tribes continue to do rain dances in spite of data showing they are ineffective. People do not change their driving and smoking habits in accordance with actual data. They follow a style of belief and behavior.

COMMUNITY PSYCHIATRY IN MODERN WARFARE*

Matthew D. Parrish, Major, MC, USA**

What can the American community expect in modern warfare? Most people agree that there will be large groups of casualties producing a sudden drastic effect on entire communities--casualties caused by atom bombs, fallout, biological warfare, chemical warfare, or perhaps weapons unknown to us. As far as the psychological management of casualties is concerned, the community will have fewer live psychiatrists, psychologists, social workers to help in the civilian communities. How can we utilize the existing resources of the community to get back on their feet as a well-functioning society?

Disaster in massive doses is far from unknown to us. We know a lot about military disasters, from cavalry charges to atom bombings. We have studied the Mississippi floods, Kansas tornadoes, various fire disasters, Texas City explosion, etc. These disasters have shown us that, in general, people lose effectiveness in a certain pattern of distribution among the community population. A short time after the impact of disaster about 15 per cent of the people have become quite effective. They grasp the situation and can lead others. Over 50 per cent perceive the situation all right but are unable to act effectively about it. They need leaders and they know they do. Their need forms a great pressure to produce leaders out of the most effective 15 per cent. There is a lower 15 per cent, however, which are obstructionistic to social functioning. Some of these are numb and helpless, some are over-excited and run around trying to excite others; some just do stereotyped activity like picking up all the broken glass.

Now, this pattern of distribution is a general one which you will find in existence some minutes or hours after impact. Two seconds after impact, however, 99% of the community would fall into the class of completely ineffective people; but following the impact, more and more people pick themselves up, look themselves over and then look over the other people near them. They begin to find themselves a place in social and work groups which are forming. As time goes on the society improves until it has re-established all its old institutions on at least a makeshift scale. This society now adjusting to its wounds has its hospitals, morgues, eating places, dormitories, courts, churches, place of entertainment, etc. Everybody now plays some familiar role in the group, even if that role is in jail.

Thus, the behavior manifested after disaster is one that can be expected to change spontaneously with time--though we can do things to hurry the change or to slow it. This behavior does not constitute mental disease--in fact, people who have chronic mental diseases have frequently been known to become most effective during the disaster. They may or may not relapse afterwards. It is important that we do not treat this "abnormal" behavior of disaster victims as if it were mental illness.

Now, what are the factors affecting the speed at which the community reconstitutes itself under stress?

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* Address to 18th Annual Conference of the Women's Auxiliary to the American Medical Association, 3 October 1961.

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1. The intensity and direction of the stress--thus an atom bomb has more intensity than an artillery bombardment.

2. The training and experience of the community--thus trained soldiers maintain themselves as an effective community under pretty severe disasters. The people of Kansas handle tornadoes very well. The people of Worcester, Massachusetts, are more disturbed by tornadoes. Without prior training the population tends mostly to downgrade the signs of danger. They avoid adequate preparation.

3. Group cohesiveness--thus the members of a military company or a religious group are able to depend on each other better than, say, apartment dwellers who never speak to each other.

4. Leadership--that is, the presence of familiar figures who interpret the situation for the rest of the people and make decisions for the group.

How can a community develop training and group cohesion prior to disaster? First, by drills and practice: Some group cohesion is developed in the process of carrying out practice runs of the disaster situation. The familiarity among people that comes of practicing together makes it then easier to work together even when struck by unforeseen weapons. During this training period the people must establish methods of communication which can still be used in the emergency. That is why we use portable radios and loud speakers, in disaster we might use helicopters or small airplanes to bring news or directions to people.

How can a community manage its psychological problems during or after disaster? First of all, community leadership should act so as to increase group cohesiveness by giving people a working role to play in the group. Some of the people can be put to work caring for others. Doctors and other community leaders will probably find themselves arranging for the well people to take care of the sick rather than actually giving all their attention to patients. This would apply particularly to psychiatric casualties, remembering that these psychiatric casualties are not to be treated as mental diseases. For experience has shown that there is no increase in the rate of psychosis during disaster. These people must be managed for the most part by giving them useful work or a short rest period, with the expectancy that they will soon perform useful work. Experience in combat and disaster has repeatedly shown that to put these psychiatric casualties in a hospital is generally to make them ill.

The principle of treating these psychiatric casualties on the spot and expecting 99 per cent of even the severest to return to normal in a couple of days is a thing which has been forgotten in peaceful intervals and has had to be learned the hard way after each of the disasters and wars of this century. What can we do today to insure that these casualties will be properly handled? The first way is by teaching the communities as you and I do even now. Psychiatrists and related professions who are cognizant of social psychology and group dynamics can teach by lectures, writing, and conversation, making the people and their leaders more aware of certain psychological dangers and of practical, preventive measures. The second way is by consultation during and after the disaster. The

psychiatrist consults with the community "caretakers"—that is, the parents, doctors, judges, foremen, and wardens. This consultation is usually at the call of the "caretaker" and is centered around some problem falling under the caretaker's responsibility. For instance, a general practitioner responsible for a patient may be puzzled by his illness. He may call an internist to help with the diagnosis. The internist, if he acts as a consultant in this sense, then encourages the general practitioner to use his own skills and knowledge in such a way as to make his own diagnosis. Thus, the "caretaker" is strengthened in his ability to deal with his responsibilities. If the internist makes the diagnosis himself and informs the general practitioner, then this internist is only acting as a teacher or perhaps he is only acting as an evaluator. The general practitioner may then become more dependent and does not increase his skill as a "caretaker." The medical profession, of course, has been doing consultation for centuries but in the past few decades it has become common for courts, prisons, schools, industries, and governments to employ consultants. A community leader can make available to himself right now the consultation ability of some community-oriented psychiatrist, psychologist, or other mental hygienist whom he can understand and trust. During a disaster the leader then has someone to think along with him about the mass management of the social problems that arise, including not only the so-called psychiatric casualties, but the problems of delinquency, displaced persons, etc.

SUMMARY

Prepare for mass casualties by:

1. Training key leaders to work together and to use consultants.
2. Drills and practices in the community.
3. Expecting every "psychiatric" reaction. To return quickly to effective work. Treat no one as if he were a long-term psychiatric case.

30 July 1962

COMMENTS ON MHCS WORK

by

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Definition

The MHCS is an inter-disciplinary faculty of men which helps a military community and all its sub communities and units to improve the effectiveness of its human relations--preventing noneffectiveness due to emotional cause or to human relations difficulties. Its primary mission then; is prevention, not treatment (below it may be seen, however, that the treatment of certain cases has preventive effects.) The MHCS is a medical activity coming under the direct supervision of the Post Surgeon when properly used, and it is not a part of a hospital. The MHCS is not an NP outpatient clinic. Its building is situated in a troop area distant from the hospital. It does not have a hospital or dispensary atmosphere and its members seldom wear white coats.

Consultation

The primary method of operation in an MHCS is consultation. Consultation occurs when the consultant helps the consultee to utilize his own resources to work out the problems that develop among his own clients. A consultee is any person who has responsibility for other persons; he is not a patient. In its purest form consultation does not involve teaching anybody anything; it does not cure anybody; it does not diagnose anybody. It does not give anybody orders, nor tell anybody how to run their business. Consultation is as old as medicine; when a doctor has a problem in medicine that he can not quite cope with, he calls in a consultant. If the consultant acts purely in a consulting capacity as we are defining it here, he would either go over the patient with the doctor or he would go over the doctor's findings and thoughts about the patient. He would get the doctor to think more clearly about the patient, removing from the doctor's path any blocks to his thinking, helping him surmount any prejudices which were distorting the picture for him, getting the doctor to remember and utilize all his knowledge and to relax enough to think creatively about the patient. The consultant never takes the patient away from the doctor. He never makes the doctor dependent upon the consultant by telling him what to do or by trying to impress the doctor with how smart the consultant is. When the consultant leaves, the doctor has less future need and may in fact never have to call the consultant again on this kind of case. In actual practice of course, consultation is often mixed with teaching or other activities. MHCS does not avoid any of these useful techniques, but its primary concern is consultation itself. In MHCS work, most of the consultees know more about their own clients and their own professional work with those clients than the consultant knows, for instance; the commander knows more about the management of men, the teacher knows more about pedagogy, the confinement officer knows more about penology. The consultant, however, enables the consultee to utilize his skill more creatively and more resourcefully.

Mental Hygiene Theory

The psychiatrists, psychologists, social workers, and technicians who work in an MHCS are often called Mental Hygienists. This is a somewhat broader term than Mental Hygiene Consultants and includes the other work they do such as holding group conferences, screening of prisoners and fliers, research, lecturing, etc.

The Mental Hygienist generally is well versed in the following two concepts. (1) He conceives of the physical and mental symptoms of an individual as being a part of a whole organism, most of which is normal and has many assets. He realizes that a symptom may have become temporarily necessary in order to maintain the equilibrium of the entire individual organism. He considers the patient "as a whole", he also considers non-patients as "wholes". He is non judgmental and listens to all sides of a problem with equal interest. He is not "taken in" by the patient and his symptoms, nor by the patient's accusors or sympathizers. (2) While the Mental Hygienist considers the individual patient or non-patient as an individual in his own right, having the distinct autonomy of a single cell; nevertheless, he realizes that the individual is, like a human cell, part of an organization of many individuals which forms a larger organism having a life, a mission, and a mind of its own. Just as the English language can grow and change with some predictability quite apart from the individuals who speak that language, so also can a company, a family, or a therapy group develop attitudes and skills quite apart from the individuals who compose it.

If the Mental Hygienist can keep these two concepts in his mind--(1) the individual organism, and, (2) the social organism--and apply both of them to every problem he meets in mental hygiene work, he will perform the work much better. These concepts are something like languages, one story may be told better in French, another in German, but that does not make one language more valid than another and you will need to use both if you travel very far.

Because of his exclusive hospital training, a psychiatrist going into MHCS work for the first time considers one-to-one therapy the most stimulating and the most educating work that he can participate in; he soon sees, however, that if he trys to treat a group as an organism he will have to use all his knowledge of individual dynamics and in addition will develop skill in the group dynamics which transcends the individual. The powerful but unseen group forces determine much of the behavior of both psychiatrist and patient during their interview. The psychiatrist also discovers that it takes even more skill and it is even more interesting and educational to be a consultant and enable others to handle better their own groups and clients. Ironically he finally discovers that the highest skill of all is developed by the consultee who knows how to change and grow by using a consultant.

There are many projects, programs, and activities proper to MHCS but no MHCS works on all of them equally at the same time. Usually one or two projects are worked upon with special vigor and when that activity requires somewhat less attention, the MHCS concentrates on another project.

Some Specific Activities of MHCS

Below are described some activities of MHCS, some of these activities overlap or are different aspects of the same activity.

I. Military units refer patients to MHCS for "psychiatric clearance" when administrative discharge is being considered. The MHCS evaluates the problem from the point

of view of the patient but then goes back to the unit, finding the unit's own point of view and also finding the role this patient is playing in his total social organism--in his squad, his company, family, classroom, or whichever is the most important organism here. Often the significant organism to be worked with is the one which referred him. Since the referring unit usually has definite emotion or anxiety about the case referred, this emotion can be utilized as a lever to gain knowledge of the company's dynamics and also to help the company modify it's behavior and attitude. Usually it is important to maintain an expectation that the company can handle the problem itself without resorting to drastic actions. If MHCS gives the patient a definite diagnosis of any kind, it may encourage the unit to insulate itself from the patient who is now seen as someone different from "us fellows who have no diagnosis." If MHCS hospitalizes the patient, advises that he be discharged from the Army or even puts him into intensive treatment, it again insulates the patient from his unit and it may weaken the unit's ability to handle that problem and others. As a consequence, the unit may refer more and more problems to MHCS for management. If a patient is really to be understood as a whole, he must be seen in situ; he must be understood in the context of the social group where the problem developed. Thus many Mental Hygienists will meet with the patient and his squad together in their unit area. The Mental Hygienist can then see clearly the role the patient plays in his squad, he can bring the squad's group-integrative forces to work in helping the patient to commit himself to his membership in the squad and in helping the squad to concur in this emotional commitment. Sometimes a Mental Hygienist does not work with the squad, but brings together in the unit area the First Sergeant, the patient, and a couple of his co-workers. In any case, the Mental Hygienist gets to know the Commander, First Sergeant, and any other influential members of the unit and he consults with these people regularly so that many problems are handled before they even become patients.

II. Every prisoner in the stockade is screened by a Mental Hygienist, the problem is then followed back to the prisoner's unit and discussed there. When the prisoner is to be restored to duty, the Mental Hygienist trys to see that the company has worked out its feelings in such a way that it does not reject or punish the ex-prisoner all over again by seeming to have no place for him or need for him or by putting him on an exceptionally unpleasant detail the very next day. The stockade screening also allows the Mental Hygienist to get an idea of the code of living the prisoners maintain among themselves and of the various group forces at work among the prisoners. The Mental Hygienist also becomes well known and appreciated by custodial personnel. With the concurrence of the confinement officer, MHCS sometimes conducts regular group meetings of custodial personnel which tend to bring out the difficulties of managing a prison, to stabilize the entire custodial group and to make rehabilitation and restoration of the prisoners much more certain.

III. A Mental Hygienist frequently conducts conferences or seminars with the NCO's of a company, or with the battalion NCO's, or officers. These conferences allow the people concerned to develop their resources much better and it gives them a better insight into the emotional workings of their own units. Many MHCS's also conduct within their own building a weekly group meeting consisting of a representative from the stockade, the chaplains, the post personnel office, the Staff Judge Advocate's office, etc., usually there is also a regimental or battalion commander present. These meetings do not bring together the chiefs of these offices, for these men get together formally anyway. The meeting at MHCS is usually so informal that ideas flow easily and the inside workings of the post are seen as a whole. It is easy at this meeting to consider the improvement of such things as accident rates, indebtedness, delinquency, etc.

IV. The MHCS's keeps a card or chart on each unit that it deals with, it often assigns to that unit a particular Mental Hygienist who consults with the leaders and who participates in every mental hygiene problem.

V. The MHCS may conduct group therapy in or out of the MHCS building. It may use group techniques to evaluate patients or even to help in the intake process. Thus a group of men being screened for work in isolated regions may be made to interact with each other in a group and so to reveal aspects of their personalities not apparent in individual interview.

VI. The MHCS, often in coordination with the Army Health Nurse, can conduct family therapy; in fact, whenever a dependent is the presenting symptom of a problem, the sponsor is always brought into the problem. He is expected to be responsible for the mental health of his family. MHCS acts mainly as a consultant in order to get a better grasp of the kind of family problems which occur on the post; he may in the company of the Army Health Nurse visit the family in its home after working hours and thus obtain clearer data.

VII. In the case of the aviation detachment the flight surgeon can act as the consultant in mental hygiene as well as in general medicine if he is backed up properly by the Chief of the Mental Hygiene Service. Thus the Chief need not assign a Mental Hygienist to this unit.

VIII. The MHCS attempts to control the epidemiology of debt addiction, alcoholism accidents, unwarranted sick call, delinquency, etc.

The Methodology of Preventive Intervention

The following experiences are taken from several MHCS's in dealing with this epidemiology.

a. Indebtedness: By conferring with groups of First Sergeants in a battalion or regiment the Mental Hygienist can get a good idea of the magnitude of the problem and the sergeants will frequently work out methods for the units to deal with the problem in a better way. They will also reveal some areas which are outside their control, as for instance the idea that the Army is in effect a huge bill collection agency which can be employed by a commercial company free of charge. The practices and characteristics of certain local salesmen will also be revealed as well as the practices of some of the debtors. This information is valuable to the Mental Hygienist when discussing the problem with the post commander. Therapy groups can be formed of debt addicts who have reached the point of facing court martial or discharge for their chronic indebtedness. The members of these groups often reveal to each other certain weaknesses and also certain assets of which they were not formerly aware. Sometimes the group will add up its total group debt and each member will try to decrease that sum by paying off his own debts. Occasionally the wives are also brought to a group meeting and their contribution toward and against indebtedness is worked with. Some debtors are so compulsive in their buying that the groups may appear similar in some ways to Alcoholics Anonymous groups. Sometimes psychodrama techniques have been useful in getting control of the emotions and the thinking that leads to indebtedness.

b. Alcoholism: Is most frequently dealt with by cooperation with a local Alcoholics Anonymous Group; when MHCS has close contact with a unit, it can often get the unit to stabilize the alcoholic before his drinking affects his duty. Some posts give alcoholics the choice of sticking seriously to a therapy group or else being discharged from the Army.

c. Accident Prevention: MHCS may meet in a group with the safety officer, police operation's officer, a commander, engineer, aviation medical officer, etc., and consider the incidence and types of accidents as well as the types of units and individuals involved in them. A Mental Hygienist considers the group attitudes which tend to provoke accidents--such as fearfulness, depression, anger at command or at equipment The Mental Hygienist trys to get the group anger or other emotions worked out or channeled into safe activities on or off duty. MHCS considers with command, the psychological influence the environment has on accidents and why the influence is allowed to remain. For instance the appearance and location of a road may say "go" so loudly that many drivers do not perceive an ordinary stop sign.

d. Unwarranted Sick Call: One or two MHCS's have set up research projects on this but a great deal more needs to be done. For a couple of days the MHCS may quickly screen every soldier that comes on sick call, studying the types of complaints and the units which originated them. With its knowledge of the styles and origins of unwarranted sick call, MHCS can work closely with the Post Surgeon and with Command in controlling this problem. Practices that have been found effective from time to time are: (1) to make every chronic complainer an emergency, seeing him immediately and sending him back to duty when warranted. (2) To hold sick call on the soldier's own time or at least at a time when he could be doing something more pleasant. (3) To have the men of one unit see the same doctor every time. (4) To reintroduce the soldier with psychogenic complaints into his squad or company by means of a group conference. On most posts, it is routine for the psychiatrist to handle all the stockade sick calls. This enables him not only to control the sick call but to get a better grasp of the prisoners whom he must understand anyway.

e. Delinquency: Keep records of the incidence and the styles of delinquency. The MHCS may study how a particular company singles out a soldier to be a delinquent and how other companies and NCO's control delinquency. MHCS and Command usually expect a military group to prevent larceny, AWOL, etc., among its members. In studying the code of behavior developed by the prisoners in the stockade--MHCS influences the stockade's tendency to make a confirmed delinquent of a prisoner.

HEADQUARTERS
DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
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IN REPLY REFER TO

CONCEPTS WHICH FACILITATE THE TEACHING AND PRACTICE OF COMMUNITY PSYCHIATRY

Matthew D. Parrish, Lt Col, MC
August 1962

Learning as Phylogeny: The concept (transferred to learning) that ontogeny accelerates its racapitulation of phylogeny as later species develop. Thus today's residents pass more rapidly through the periods of dedication to demonology, nosology, developmental psychology (with its individual unconscious), ego psychology, inter-personal theory, psychiatry of the community organism, and so on.

Learning - As Character Change: The concept of teaching by dealing directly with the current emotional processes which develop in group and individual as learning proceeds. Learning then, is not just a piling up of knowledge, but an acculturation - a change in character, outlook, identification.

Group as Organism: The concept of treating a group as an organism in itself (in addition to treating individuals in the group.) This is W. R. Bion's theory but it is applied here not only to the artificial group-therapy but to natural social and working groups - families, classrooms, hospital staffs, industries...

Mind as Plexus of Cultural Forces: The reawakened concepts of the past one hundred years on how individual thought processes are shaped by contemporary group culture (Tolstoi, Durkheim, Poincare', Spengler, Sapir, G. H. Meade.) The individual of superior intuition and intelligence is considered a focus where the wave-fronts of current cultural progress converge and become conceptualized as "original ideas." The ability to conceptualize becomes the crucial skill here and is abetted by: "intelligence, learning, motivation, the style of thinking current in the group and by being in the right place to grasp pertinent feelings and information." Since a sensitive person picks up many of these from the ambient culture, without being aware of it, he may perceive them as arising from within the self. It is more ego-satisfying, of course, to think of thought processes as arising spontaneously from the individual - paralleling the concept of spontaneous generation of bacteria. But this concept alone does not allow enough freedom of operation in dealing creatively with a community's potentialities for learning, teaching and inventing.

Patient as Symptom: The concept of the patient as a symptom - of the deviant or disturbed individual as one symptom of a group's disturbance.

Interchangeability of Symptoms: The concept of the interchangeability of neurosis, delinquency, accident proneness, psychosomatic diseases, unemployment etc, in reckoning the epidemiology of mental disease.

Community as Cause and Cure: The concept that only a mental health service; accepted by local churches, businesses, schools, police, neighborhoods can deal with the organisms from which the symptoms (patients) spring. Only such a service, then, can teach the ultimate causes and the stable resolutions of mental disturbances. Pinel advised that residents be trained in hospitals where the mentally ill were clustered. But such clusters are artificial groups with new problems of their own which develop new symptom-patients.

Caretaker Consultation: The concept of crisis consultation and also routine consultation with community "caretakers." That is, consultation with fathers, teachers, judges, physicians - with people who have responsibility for certain other people - in an attempt to strengthen the caretaker's ego so that he employs his own skills better. (Gerald Caplan).

Cross-Professional Work: The concept of the cross-employment of psychiatrists, social workers, and psychologists (minimizing the use of psychologists as routine testers or of social workers as history gatherers).

Technician's Responsibility: The concept of using well-trained and supervised para-professional technicians to do much work which was but lately regarded the sole privilige of professional workers. On some Army posts, these technicians go out into the field to see a problem in the very group it developed, but they carry the precept that they don't diagnose anybody, don't cure anybody, don't advise anybody. Many psychiatrists would at this point say, "But what's left to do?" The technicians however, facilitate the group's intensive communication organized around its problem - making the problem primarily the responsibility of the group and its leaders.

Ward as Community: The concept of the hospital psychiatric ward as a community of patients and staff with some interchangeability of roles (whether desirable or not) - the particular symptoms of a psychotic patient being determined in large measure by the ward itself. Introduction of a new patient may shift the role equilibrium of the whole ward. Therapy is a system of living participated in by doctor, nurses, and patients. The outside community provides a consultant. The ward doctor himself, is not considered an outside person who injects medicines, advice etc, into the group system of the ward. Rather he is a role-playing member of the group itself. The doctor also pays a lot more attention to the therapeutic importance of the corpsman, who spends eight hours a day with the patient, and of the patient in the next bed, who spends twenty-four hours a day with him. (Artiss).

Dedicated Myopia: The concept that when a group's work identification is exclusively with the problems of a single specialty, then it tries to increase the personnel and the budget of its institution without regard for other institutions in the community. (Northcote Parkinson). In order to be effective, the psychiatric resident must become intimately acquainted with the syndromes, the patients and the practitioners of the profession through hospital training, but in so doing he usually becomes as interested in morbidity as the surgeon, who says, "I haven't done a good thyroid in months!" He is not oriented toward prevention. When in the extra-hospital stage of training, however, the psychiatrist can identify himself with the total community (not letting a community clinic insulate him) then he develops skill in action for mental health. Thus he can become a broadly responsible consultant to community mangement.

Truths vs Facts: The concept that scientific and academic truth in the lore and principles of the profession is polarized against manifest social fact in the daily life of a particular community. The truths include the models and theoretical constructs which pattern our perception and our planning. They require an intellect which applies each principle many times - validating and making it communicable within the total profession. The facts include the acts and events in a day which is lived but once. They require flair for effective intervention which deals with each matter uniquely. This polarity of truth and fact accords with Aristotle's idea that a fable has more truth than a news report. Typically the scientist is at home with one pole, the politician with the other. The community psychiatrist must be equally at home with both.

These thirteen concepts are themselves in statu nascendi. To embalm any of them into eternal principles would blind one's self to progress. The practice of community psychiatry constitutes a river we cannot step into twice.

THE SERVICE PSYCHIATRIST - ADMINISTRATOR OR PHYSICIAN

1962

MATTHEW D. PARRISH

In our medical schools and hospitals we prepare our young psychiatrists to be a personal physician to a particular type of patient. And yet it is often said that in practical military psychiatry this dedicated physician must also become an administrator. He must make his diagnosis and treatment fit a practical military situation. Is this not to the detriment of the physician? of psychiatry? SZASZ[1] makes graphic this dilemma.

Let's examine this schism in the military psychiatrist. Most young doctors choose to go into psychiatry thinking that they will deal closely with one patient at a time. They will get to know his personal feelings, the intimacies of his private life, and the most delicate nuances of his thoughts. They will help him with problems which are assumed to be only his own personal business. In most training hospitals the psychiatric resident does just this. And in addition he learns to affix to each patient a diagnosis which enables psychiatrists to make predictions about the patient and to manage the treatment according to established principles and techniques. The treatment is directed at the patient personally and generally these young hospital psychiatrists are absorbed in their work with individual patients. They are dedicated to it heart and soul.

When the psychiatrist gets out into practical military work, however, he finds that the diagnosis is not something that belongs only to the individual patient and the psychiatric staff. On the contrary it belongs to any social group that knows it. The diagnosis enables the layman to classify the patient as different from the general run of non-diagnosed men in the neighborhood or the work group. Even without diagnosis, the very fact that the patient has been treated on a psychiatric ward brings society to approximately the same conclusion. The psychiatrist finds that if he hospitalized the patient and makes the diagnosis, then society will modify its own behavior toward the patient sometimes profoundly affecting the patient's ability to adjust to society.

For example, a basic trainee may come to the psychiatrist wearing his uniform wrong-side out and may still not show evidence of psychosis. If now the psychiatrist diagnoses him as neurotic, or even as passive aggressive, the patient's company will usually redefine him as some sort of oddball -- that is, "not one of us". But if the psychiatrist says he is just upset by the service and is trying to get out, then the patient becomes a problem for leadership. His peers may then say "some of us want to get out of the service, too, but we aren't going to and you aren't going to either. You are one of us." The patient is still a member of the group and the group will eventually train him.

Thus the commander will often refer a patient to psychiatry with the idea that the psychiatrist may give the patient some sort of diagnosis which will explain why he should be discharged from the company of military men -- so that the commander will have fewer worries. In this way the psychiatrist is asked to help take care of an administrative problem defined by the company. The patient himself may try to make the psychiatrist rescue him from the necessity of having to adjust to the military organization. On the other hand the patient or even the commander may appeal to the psychiatrist to avoid diagnosis or even treatment because this would ruin the patients' chances for promotion. Sometimes those congenial, loveable, generous, and often jolly men who live close to the bottle are protected by their fellows year by year until they reach the verge of court-martial. If command and the psychiatrist desire to reduce alcoholism they may have to collaborate closely as commander and staff officer in order to manage the problem.

Accordingly there is a great deal of social pressure on the psychiatrist to diagnose, to treat, and to advise in a way that society can tolerate or perhaps even enjoy.

Can the psychiatrist now abandon his integrity as a physician and manage a case in accord with the needs of a company rather than the personal needs of the patient? Let us see what modern military psychiatrists are doing! In the Army's Mental Hygiene Consultation Services, in the Navy's work with groups in the antarctic and other places, in the Air Force's concern with flight crews, the psychiatrist addresses himself to the social and evnironmental forces which produce deviant behavior and thinking. The patient which he examines, in situ, -- that is, in his own work group, -- has one set of characteristics and the same patient seen in the hospital has another. The original patient actually had the capability to live according to several behavior and thinking codes. In one group, say in a submarine crew, he behaves according to one pattern. In another, say at home, in the hospital, or on liberty in a foreign port, he conforms to other patterns. Indeed basic training itself attempts to re-form men, to ingrain them with sets of reactions and codes of living which are dependable for the military, but which may not especially improve the family or factory. The psychiatrist aids the process of basic training not only by helping to eliminate those who couldn't make the change over to a military life but also to help commanders contain and train men who are especially hard to acculturate because they are prone to get themselves classified as non-members of the group. The psychiatrist sees the patient not only as an individual with a certain personality development over the years but he sees him, in situ, among the group forces of his company. In other words, the psychiatrist understands the patient better because he understands him not merely as a well-integrated living person but as a part of a larger organism without which his life would have no civilized meaning. The skills, the intelligence, the human qualities have their truest meaning in the context of the society. The modern military psychiatrist, acting as a staff officer to command considers the entire society to which the patient belongs. Some of the most important therapeutic forces are those which can be elicited in the patient's military unit.

Let us consider the work of the Army's Mental Hygiene Consultation Services. The mental hygienist as the psychiatrists often call themselves consult with command, teachers, confinement officers or, in short, with anyone who has responsibility for other people. They meet in group sessions with the NCO's of a unit or even with all the unit troops. They concern themselves not only with depression and phobia but also with delinquency, accident proneness, and unwarranted sick call as manifestations of the trouble the individual has adjusting to his role. Since one of these symptoms may sometimes substitute for another the mental hygienist thus has a broader grasp of the whole patient, as well as his society. In the Air Force the flight surgeon knows that it may be the pilot's family which grounds him and so a whole range of social forces is considered. The Navy has strong interests in analogous work with regard to groups working in isolation on ships.

Considering the experiences of prisoners in China, Lifton, Hinkle, Wolff, and others have described the so-called "brainwashing" type of regression which was followed by a re-forming of the individual's behavior and of the ideals he becomes habituated to. Here it is mainly the lack of humanity that is new. There is nothing new about the re-forming of ideals and behavior structure. This, occurs, for instance, when an infant is weaned; when a child goes into the first grade; and when a civilian becomes a soldier in basic training. The civilian with great personal emotion may pledge his allegiance to his country but he is seldom ready to die for that country until he is firmly a member of an organization which may be committed to combat as a unit. In the future, it may be necessary to train in greater numbers those servicemen who perform in isolation -- the reconnaissance pilots, the scouts, and so on. But the military units of these men are often the most closely knit of all. The military psychiatrist will not fail to consult upon the relations of these men to their unit as a whole.

The military psychiatrist, therefore, is a physician. The patient can talk to him freely and the psychiatrist can perceive the patient intimately with all the personal skill of any other physician. Concerning human relations problems the military psychiatrist is also consultant to the administration. He talks to all echelons of command and staff with equal ease and he is, therefore, the one consultant acting directly and personally on all the levels of the military community which have a bearing on the problem. He facilitates thinking in an individual patient by helping to remove emotional blocks, prejudices, habits. He likewise facilitates communication and creative formulations within units. He wants to help each group to stabilize itself so well that it produces no patients, no prisoners, no accidents, no security breaches nor other signs of noneffectiveness.

(1) SZASZ, Thomas: Psychiatric Quarterly 33: 77-101

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LABOR AND PSYCHIATRY

By M. D. Parrish

Reference:

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Adolf Meyer felt that he could not account for much that he had observed in human relations without postulating that the individual is born with many fixed and unlearned tendencies. (Actually, the individual is born into a social world which has fixed tendencies, unlearned for the most part in the present era. This world injects these tendencies into the individual.)

33. Man could not have survived till now if he had not been born with unlearned tendencies--considering that a newborn is so helpless. (Actually, modern newborns have been biologically selected over the past 10,000 years to be born into a social group--a world with language and other human mores. He is fit to learn a grammar, not to find worms in the woods. If he is mechanically nurtured outside a human group so that he has good physical development, he will probably die even before being set out in the woods to fend for himself.)

39. (Gregariousness is not an innate instinct, but rather something that is demanded of the individual from the moment of birth. Mother, nurse, and other society demand that he be responsive to the group forever. If he cannot, he is called autistic, etc.--that is, he is not human. Mud dauber wasps would be seen as having gregarious instinct, too, if we defined those who were not gregarious as "not mud dauber.")

49. If the middle class demands that the laborer get the same satisfaction for his needs and "instincts" that it plans for the college student, then the laborer, with his monotony, his indignity, his sexual apologies will develop the middle class fixations and inferiority obsessions (the overcompensations). This will produce either (1) an inefficient worker, who abandons his family, traditions, etc., or (2) strikes and sabotages in order to eliminate the inferiority in his own eyes--to dignify the self. "His condition is one of mental stress and unfocused psychic unrest, and could in all accuracy be called a definite industrial psychosis. He is neither wilful nor responsible, he is suffering from a stereotyped mental disease."

40. Highly paid labor also has unrest. One New York City store with 3,000 employees has had 13,000 persons per year pass through its employ. Big business dehumanizes, with its efficiency systems, its discipline, and its task systems. It produces unrest, even among the highest paid. The usual sort of efficiency is gained through industrial psychosis. To cure unrest we blindly trust to a wage scale which expands with time--a 10% increase in wages every few years. A narrow thwarted life drove unmarried women to the AEF in World War I. It drives college students to athletics because of perfunctory and dull teaching in the universities. "College athletics is a sort of psychic cure for the illness of experiencing a university education."

51. A strike is an inferiority compensation of the industrial worker and has two prerequisites: (1) The worker's obsession, and (2) decay of social mores in the eyes of the laborer to allow the breech of law and convention necessary for a vicious strike.

54. A program of reform: Gather a militant minority...a small Herd..." to "give counsel, relief, and recuperation to its members"...who otherwise "would be branded outlaws, radicals, agnostics, crazy...lucky to be out of jail most of the time." These people would work by trial and study as Sidney Webb and Fabians did. —Recruit from universities a very few persons. Most are helpless shams. Recruit from the field of mental disease speculation and hospital experiment. This field produced Freud, Dewey, Morton Prince, Pierce Bailey, Thorndike, Meyer, Stanley Hall, Adler, Watson. Comparative abnormal psychology will challenge industrialism and make a program of change.

(Probably the Herd should really come indiscriminately from any profession. Some professions would be lucky to provide even one member.)

The reform program should "exclude children from formal disciplinary life, such as that of all industry and most schools up to age 18." To understand what to do with them, read John Dewey: The Schools of Tomorrow (it tells) or his Democracy and Education. The learning activity should be an active trial and error process. The children should recapitulate, with guidance, the human race's trial and error learning experience. Wisdom comes from experience, not from books. The educators should unstifle leadership, workmanship, hero worship, hunting, migration, sex. They should teach workmanship, not by giving the child a mechanical puzzle but an Erector set, or better, ten dollars worth of lumber and some good tools. (American tools carry Western culture within them.)

After age 18 the student should go to an undergraduate university. The first two years consist of a science of human behavior. The university would teach much of today's biology, zoology, and history (if it is interpretive), and psychology (if it is behavioristic), and philosophy (if it is pragmatic), and literature (if written spontaneously). The last two years of the university would use the standards of value gained in the first two years to appraise the institutions and instruments used by civilized man.

57. Institutions, instead of molding men's habits to assist the continued existence of the inherited order of things, should themselves be molded in the interest of "scientific evolutionary aims and large human pleasure."

Business and industry must be de-emphasized in favor of most other ways of self-expression. (Status-seeking is a product of Western business, universities, and other institutions of the expanding economy of waste and poor workmanship and no creative art. Compare Florence's closing down for a holiday, about 1300, to bring Giotto's new painting into St. Mark's.)

59. The problem of industrial labor is equivalent to the problem of a discontented businessman, the indifferent student, the unhappy wife, the immoral minister (not just in personal life). It is a maladjustment between a fixed human nature (?) and a carelessly ordered world. To begin the cure, break down the inhibitions to free experimental thinking.

#13

(Letter from Psychiatrist in Frankfurt A.M.
to Psychology Specialist in Fort Belvoir)

December 31, 2163

Dear Tom,

Here in the last microsecond before the programmed ending of Time and the instituting of Perfect Social Security I'll write optimistically of the future--as you have suggested. But first let me muse romantically on the past.

Optimism is easy when you consider that the future is determined only by the laws of nature and the present status of things--not at all by the past. In like manner the few pieces remaining on the chessboard determine the remaining game. The moves that went before need not even be known. The romance of the game, however, lies in how Black and White got themselves into that end-game position. Romance is a flux, not a status.

History, like meat on a block, can be chopped any way you like. To-second I feel myself influenced by the romance of the Age of Chivalry which indeed influenced so much of modern manners--though of course the Age of Chivalry never existed at all but only came into being in men's minds after it had supposedly died.

History, as I chop it, is the romantic evolvement of man's freedom. Centuries ago some men felt that the universe revolved around their own hearth, that man was a specially privileged ruler of the world segregated out from other animals, that history was a procession of events culminating in "modern man" as the most complex being, and that every man had freedom of choice in his own mind (which was considered to repose within his own skin). Eventually man grew free of all those notions.

The invention of the Copernican astronomy set man somewhat off center and wounded his pride. On the other hand, he would have fallen on his ear if he had tried astro-navigation under the old concept. Realizing his subordinate position, he became more powerful.

The invention of evolution freed man biologically and enabled him eventually to better his race--though it set him on a continuum with other animals.

The invention of the subconscious mind freed man to use more of his mind --though at first he was piqued to find that he was not even aware of most of his own thinking.

The invention of destiny freed man to realize that his history swept on in spite of him. Changes in languages, styles of thinking and living, world ideals, art forms all received the meagerest of shaping from any calculated acts of individuals. An American accordingly thought with certain inherited human instincts and never with apian instincts. He thought in the English language but could not with the Eskimo. He thought in the style and prejudice of his own decade, not in any other. The invention of this destiny-ordered concept of human history, however, freed man to act more surely while remaining so ordered and eventually even to navigate around in destiny. He would have fallen on his ear if he had tried destinavigation with the 20th century concept that man was autonomous and could think his own private and independent thoughts.

Still I believe that modern times began in the 20th century; for then the human animal began to work toward the betterment of all life. Man suspected at that time that other animals had feelings and thoughts though even dolphins were not allowed the right to vote--much less to pay taxes. That century at

least erased the fine discrimination between male and female, servant and master, child and adult. The first half of the century saw women reach equality with men, saw the invention of the 40-hour week for all but managerial and professional workers, saw an attempt at keeping down the quality of the race through selective murder. The second half of the century saw the voting age lowered to 17, saw the highest status rewarded to rational thinking (as formerly in Monasticism) so that eventually everyone became a research scientist, saw private property abolished (as formerly in Utopian Australianism) thus abolishing the most galling impediment to mobility, and finally saw Eugenics established so that breeding was permitted only to those as intelligent as Einstein, as beautiful as Mata Hari, and as athletic as Cassius Clay. The result was a momotonously beautiful, strong, intelligent race. These times too saw the development of a world-wide written language. Heretofore the non-Chinese minority of the world had never advanced beyond indicating voice sounds on paper. An ideographic, seen-at-a-glance symbolism replaced the old linear script. Doctor Zhivago could be written on one page in a single complex ideograph.

In the 21st century when man-thought achieved synthesis of coded DNA, all life began to come out of the laboratories, and the population was set to double every year. For a while the labs experimented with two-headed people who could wear two hats in the Bureaucracy, lens-eyed people with fingery lashes who could repair printed symbolic-circuits, tiny 6-legged people who could mine miniature ores for computers. Eventually, of course, computers were made biologically. Special instincts were built into the DNA code so that people were born half-educated. In time a silicon atom was substituted in the DNA thus ending discrimination between animal, vegetable and mineral peoples and rendering obsolete the SPCA. The Library of Congress was microfilmed, continuously updated by radio, and hung on everyones eyebrow. The Bureaucracy decided then to make all individuals immortal and identically equal, self-driven, coded minds of energy-matter. By abolishing locomotion, it solved the traffic problem. Reproduction by intussusception pervading all of Space ended the Lebensraum problem. Since all permutations of communication were instantaneous, everyone knew everything about everyone. Reproduction produced only an increase in thought-density.

By the 22nd century the Bureaucracy was disestablished and the Computer incorporated as the central organizing Being. Time, at first regulated by astronomy and then by nucleonics was now generated by the computer. Back in the period of the Contending Ideologies progress had accelerated arithmatically under the Bureaucracy geometrically; but now under the Computer factorially. The 20th century had laid claim to more progress than all prior history, but yestersecond saw more progress than all previous time. In the next microsecond the Computer plans to reify the Anaxagorean Universe. There will be nothing but the individualized and perfectly coded Mind--a self-thought which has outgrown Time.

How can I be otherwise than optimistic, Tom, as I contemplate the remaining microsecond of the future?

Your old friend,

Matt

#14

CONSULTATION CONCEPTS IN MILITARY MENTAL HYGIENE*

Lt. Colonel Matthew D. Parrish, MC**

The author discusses a concept in the treatment of soldiers with behavioral problems that involves mental hygiene consultation with laymen—the commander, NCO's, and other members of the unit to which the problem soldier belongs.

IT WAS DISCOVERED some time ago that most psychotics, neurotics and delinquents were *not* under individual treatment by psychiatrists, social workers, etc., but were handled by laymen. Mental hygiene consultation with these laymen rather than with patients directly has often affected the lives of these patients far more than individual treatment would.

What is consultation? It is almost as old as medicine, but watch out, it may be a new concept to you.

Here is how it works: A doctor, a general practitioner, for instance, who has difficulty in diagnosing and managing a patient with a vague abdominal complaint calls in a consultant. Now the consultant, if he acts purely as a consultant, does one of two things:

1. He goes over the patient with the doctor and helps the doctor clarify his own thinking about the patient and about this area of medicine.

2. He listens to a case presentation in which the doctor's own techniques and prejudices are revealed, and without necessarily seeing the patient himself he helps the doctor handle the problem.

Note that here the consultant has considered the doctor as a professional equal—a colleague. In medical centers, consultants do not always act this way because they are not purely consultants: they are *also* teachers and the relation between teacher and pupil often overshadows the relation between two professional men.

What are the advantages accruing to the little social system consisting of doctor, patient and family when that system utilizes a consultant?

1. The consultant brings a fresh outlook that is not so involved in the patient's life, the tediousness of patient care, or the pressure from the family, etc.

2. The doctor's own type of over-involvement—and even his mistakes—are in themselves data which tell the consultant *something* of the problem, something which the doctor or his regular assistant could not have seen.

3. A consultant usually has experience in helping others to utilize their own resources.

4. A final advantage is usually that a consultant is technically trained in a particularly useful aspect of the problem.

Note again—I did not say:

1. That the consultant taught the doctor anything, nor

2. That the consultant told the doctor how to run his business, nor

3. That he gave *any* treatment to either patient or doctor, nor

4. That he took the patient out of the doctor's hands.

Of course, there are consultants who avoid being pure consultants in that they treat or teach. There are even some people who call themselves consultants when they take over the patient, but properly this is called changing a therapists; it is not consultation.

Mental Hygiene Consultation

Mental Hygiene Consultation differs from ordinary medical consultation in that the mental hygienist consults not only with the doctors, but with all the other community "caretakers" who are responsible for the human relations within some group.

Examples of Caretakers: commanders, teachers, lawyers, confinement officers, doctors and other staff officers. For simplicity, however, let us consider here only command consultation. For this purpose then, the following definitions will apply:

Caretaker: The commander and those officers commissioned and non-commissioned to whom he delegates a part of his responsibility for the mental health and the human relations within the military unit.

Patient: Someone with an imperfect developmental history at whom the unit is currently pointing the finger and saying, "He has a problem."

Normal Persons: Someone with an imperfect developmental history but at whom his unit is not pointing the finger.

Consultant: A person trained broadly in one of the behavioral sciences who can work with the individual commander, with his patient, and with the entire unit as an individual organism which has its own behavior, symptoms, and life course.

What does the mental hygiene consultant do? Essentially, he does the same thing a medical consultant does. He helps the caretaker to clarify his own thought about his problem with the patient and to utilize to the fullest extent all the resources which the caretaker already has at his fingertips. Resources are intellectual, emotional and social. Here is an example of a consultation problem:

Consultation Problem

A commander has many troops who are having trouble with excessive indebtedness. Commanders in neighboring units are having less trouble. The commander assails the debtors bitterly as dishonest and essentially inhuman. The mental hygienist, adopting the usual non-judgmental attitude, does not condemn indebtedness as the commander has asked him to do, and eventually, from the commander's attitude, it becomes evident that he himself is fighting against a tendency to go deeply into debt in his own affairs. The mental hygienist, in accepting debtors as human and likeable enough, has accepted also this debt-anxious aspect of the commander. In the presence of the

*Presented at the 1963 USAREUR Medical-Surgical Training Conference held in Garmisch, Germany.

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mental hygienist, the commander is able to accept it also. Thus the commander has opened the door to an area of creative thinking which was formerly blocked. He can now plan much more effectively how to deal with the problem of debt in the unit. He may even stimulate his own troops to work out effectively ways of handling the problem which have never been discovered before.

Note here that the consultant did not teach, did not advise, did not treat. As a consequence, though, the commander is now stronger and more resourceful than he was before the consultation. He is not more dependent upon the consultant to come and solve this problem again and again, or to teach him more and more. The tendency of this unit to mishandle indebtedness has been corrected by the unit itself with the commander as the responsible caretaker. This kind of practice strengthens the commander and the unit as a stable and creatively resourceful organism.

Mental Hygiene

Let's look more closely at the programmed activity of Mental Hygiene.

A military psychiatrist who supports 20,000 troops may be supporting about 100 units plus the dependent families connected with these units. Now, when these units are divided among the social worker, the psychologist and the technicians, each mental hygienist may have 15 units to support. In dealing with these units, the mental hygienists often confer in groups or individually so that each technician is consultatively supported by an officer and the most experienced officers act as the consultants for the entire staff. This intra-staff consultation is frequently also combined with teaching.

Let's take the case of Company "A," a unit which no mental hygienist has ever observed before. Let's say that a social work technician is delegated to the unit and you are a psychiatrist supporting the technician. This technician keeps a book in which is recorded every unit he supports. Under each unit he records every "patient" referred from that unit plus other general observational data on the unit itself. Now this technician comes to you and says that Company "A" has referred three "patients" for administrative discharge evaluation and that, in addition, the supporting dispensary has referred one patient who has a mild phobic reaction that the unit and the doctor are now getting tired of.

At this point you must ask yourself: What is this unit trying to say to the Army Medical Service or to the unit's own higher command? What are the CO and the First Sergeant trying to say to their troops? One thing fairly certain is that the commander using on-the-spot observation and using more skill at command than you will ever possess has concluded that his unit would be better off without these three men. Similar communication is also coming in from the surgeon. You must respect these opinions. But, you may also suspect that these four men constitute a social phenomenon within the unit and not just four isolated individuals who have difficulty in getting along in the world.

You arrange a personal visit to the unit area and take the technician with you. You feel out the attitudes, policies and prejudices of the officers while the technician gets a feel for the NCO's—what are the troops, both "patients" and normals, complaining about. What are the real psychological difficulties which underlie the complaints. When you have become comfortable with the leaders of the unit you form a group of the four patients plus three or four normal troops who live or work closely with them. Sitting in the group with them you get these men to interact with each other. The more you get them to talk and to react emotionally with each other the more you learn and the more the problem will begin to resolve itself. This includes not only the problems of the four individuals, but also the style of unit rejection, cooperation and creative activity. After an hour of group observation you and your technician may see each of the four men briefly as individuals. When you finish, you have a set of notes in a form easy to type into certificates if needed. You and your technician have made a definitive formulation of any further treatment or management needed.

What, now, are the results of this visit?

1. The unit knows that you understand a lot about it.

2. It does not have to refer patient after patient in an effort to get close attention from higher staff.

3. It is led strongly to look closely at its own problems and to induce men to dedicate themselves to the unit life. This is a socially more healthy game than the game of extruding patients from the group and hoping for better luck on replacements.

4. The normal men who were in the group meeting tend to stabilize the patients and to spread the feeling that these men, when seen with medical eyes, look acceptable as soldiers.

5. OR the normal men tend to identify with the patients and again the problem becomes a group problem, solvable by some group action other than extrusion.

6. The feeling and information which are brought out into the open, not only from patients but from normals and NCO's, sometimes brings Command to say "Well, I don't really need a certificate now. I see how I want to handle this. The data is all in front of me."

7. In later weeks this unit can phone you or the technician about a problem. They feel that you know them as perhaps no other doctor or technician ever has, and they find it easy to present relatively undistorted facts and to respond readily to their own observations on the phone.

But what about the companies you didn't visit this week? What about the command consultation patients who come to your office? Suppose each one is from a different unit so that you can't even schedule two or three from one unit to be seen the same day? Well, you can still have each patient bring with him a man who lives closely with him. You can see them together as well as separately if you wish, and there again the problem stabilizes itself because of the emphasis on social validation and concurrence. The problem is not allowed to isolate itself into the dark recesses of a doctor's practice. If the technician or doctor calls the unit immediately after the interview, then the unit more readily applies its own healthy leadership to the problem.

A certificate will be more effective if written as one professional colleague to another using only language common to both professions and if it gives definite professional impressions and recommendations. The

mental status is more useful when it shows the commander clearly how the man appeared to you in behavior, motivation, mood and manner of thought. He may appear different at work and it may help command to see that difference.

This "remote consultation" done by telephone and paper from your office is certainly not as effective, nor can evaluation be socially as useful and accurate, as that done where the problem is examined in situ. Such remote consultation is no substitute but it is an adjunct.

In Mental Hygiene consultation the "caretaker" is considered responsible for the human relations difficulties of a group organism. Within that organism the "patient" is an organ which plays a symptomatic role and which the rest of the organism points out (often sympathetically) as being deviant. A patient need not be a human being. Sometimes an airplane is a patient—or a tank, or even an old office building.

The difficulty—which the organism usually considers the patient's own peculiar difficulty—is itself a communication to the medical profession. It is the group's cry for professional help. The consultant is an "outsider" who enables the caretaker to see the problem more clearly and to develop the group's own resourcefulness. "Caretaker" and consultant work together in such a way that the "caretaker's" own skills as a leader are improved and he relies more effectively upon himself. Often the entire group organism integrates itself around a complex mission of work and developmental activity so that symptoms of ineffectiveness decrease.

15

SIXTH INTERNATIONAL CONGRESS
of
PSYCHOTHERAPY

London
August 1964

Observations of Lt. Col. Matthew D. Parrish, MC, Acting as Reporter for US Army R & D Command.

HISTORY: The International Congresses began in 1948. Each has been held in a different European city. The next is to be in West Germany in 1967.

NUMBER ATTENDING: About 1000 people representing 48 countries including East Germany and several Iron Curtain countries, but not including Russia or Red China. About 100 wives of members also attended.

ATTITUDE OF MEMBERS: Most members seem to be seeking knowledge and a lot of communication with each other. Some apparently sought prestige and showed off a little but there was no bitterness nor open antagonism apparent. Members of the press remarked that in this respect the Congress was quieter than the Congress of Social Psychiatry which was held the preceding week in London.

FORMAT OF PROGRAM: The mornings were occupied with plenary sessions in the vast auditorium of Central Hall. Here, formal papers were presented and formal discussers remarked upon them. Only occasionally was there participation from the audience. Everything said was simultaneously translated into English, French, German and Spanish by means of small head sets for each member. The afternoons were occupied with workshops in some 20 different rooms adjoining Westminster Abbey and the Central Hall. Here there was much audience participation. Many papers were slowed up in their presentation by the fact that a couple of volunteer members would have to translate or give summaries in order for the entire audience to appreciate them. The evenings were occupied with formal and informal receptions and cocktail parties where various members and groups discussed their problems and developed their theories and ideas together. The first reception was held in Lancaster House where the Government normally entertains dignitaries. According to British members, this was an unprecedented honor for such a Congress. Here with unexpected perceptiveness, the secretary to the Ministry of Health discussed with me the US Army and Air Force's Preventive developments and its attempt to use Social treatment as a tool. He felt that both Britain and America had progressed far by maintaining "This Special Relationship" between them - not only in military but in all scientific and commercial work (he seemed to know of more "special relationships" than I did).

I also participated in much informal conversation with delegates from many countries at (1) The City of London's reception for the entire Congress in the London Guild Hall, at (2) The German Ambassador's Reception for German members, at (3) The Congress's own last get-together at a Country Club. In addition, there was much discussion in the hallways at lunch and coffee times. Some of the ideas expressed will be reported in appropriate context below.

There was a dazzling variety of papers and discussions. I tried to attend mostly to people and papers which seemed to be (1) most new and progressive or (2) most influential. This report is therefore not a perfect cross-section of what went on.

In reporting on papers below, I have put in parenthesis comments which the author or his colleagues made in discussion after the paper or which were made pertinently in other papers of the Congress.

THE ARRANGEMENT OF PAPERS PRESENTED: The succession of papers with each succeeding day emphasized--

1. (Mon) The total Social and Governmental view of psychotherapy--national policies development of international coordination, etc.

2. (Tues) Childhood and adolescent psychotherapy.

3. (Wed) Adult psychotherapy.

4. (Thur) Small group psychotherapy.

5. (Fri) Large group psychotherapy.

6. (Sat) Return to design of international and governmental communication and coordination.

GENERAL OUTLINE OF PAPERS PRESENTED IN PLENARY SESSION:

MONDAY: The social and governmental view of psychotherapy.

-1-

Mr. Bernard Braine, parliamentary secretary to the Ministry of Health said that psychiatry used to be considered hardly a part of medicine largely because of its lack of results. Now, better treatment results have brought better recognition. From its beginning in 19[illegible], the National Health Service considered mental illness valid as any other illness but in later years the emphasis in psychiatric treatment has turned from hospital medicine to community medicine. The government is anxious to understand community dynamics in mental illness and in treatment. There are three important questions:

(1) What is the range of psychotherapy? What are its limits?

(2) Can any nation afford freely available psychotherapy?

(3) What would be the social consequences if psychotherapy were not freely available?

-2-

Dr. Thomas F. Main (Cassel Hospital, England): The Search for Sense--The advances in psychiatry have depended on concurrent advances in other sciences. Nowadays, however, the advance of physical and biological sciences depends a great deal on further advances in psychiatry. It is in the clinical situation that a person most readily reveals himself and the blocks to his thinking. This opens doors for the understanding of road blocks to the progress of physical sciences or management. (It also opens doors in anthropology and in the understanding of developing nations and of other groups which must interact with each other). Clinical psychiatry brings a knowledge of social process which is applicable in strikes, prison behavior, the decisions of legislatures, the scapegoating of public figures, etc. Whether practical use can be made of such advances in any science, however, depends upon the kind of culture in which those advances occur. Can changes in direction be accepted?

All three of the great pivots of scientific change--Copernicus, Darwin, Freud--produced an angry incredulity in their contemporaries. Of the three men, only the psychiatrist really tried to understand the automatic irrationality he was faced with.

Only a physicist can test the results of a physicist. Only a psychoanalyst can test the results of a psychoanalyst. Every science is a closed shop (with cross-disciplinary respect, however, such threshold sciences develop as bio-geology or bio-physics. The implication is that we may some day have psycho-biology or psycho-economics).

TUESDAY: Infancy, Childhood and Adolescence.

-3-

Professor James Anthony (St. Louis, Missouri): Developments in Child Psychotherapy. Varieties and vicissitudes of the therapeutic situation in the Treatment of Children.

Child psychiatry originated with Freud--with the treatment of little Hans in his own house without strict time structure and employing father to do part of the treatment. Today, in the United States, the collusion is between psychiatrist and mother. Father is seldom involved unless he is a weak and ineffectual person. Everyone agrees that therapy would be most effective if father were involved but there is little real effort to bring him into the therapeutic situation. (Cf. the usual US Army Mental Hygiene policy of insisting that the "sponsor" be involved in the treatment of every case). After little Hans, children in general were treated like pieces of Dresden china. It was assumed they could not tolerate a sudden break through of insight. They were given strict appointments and thus child psychiatry became like adult psychiatry at the same time adult psychiatry was becoming like child psychiatry. In the past three or four years, however, children have been considered more emotionally resilient than adults.

Generally, the first stage of treatment is a "seductive" one in which the child is prepared for deeper intervention by the formation of a close relationship with the therapist which often involves close body contact and almost symbiotic togetherness. After this, the therapist can put the child in a bind by manipulating the now much desired relationship. The second stage of treatment involves a shift from unconscious and acting-out elements to verbal elements of communication in which the erotic factors are quite conscious. The transition is facilitated by more rigid appointments and an increased frequency of meeting.

-4-

Discussion by Dr. F. H. Stone (Glasgow, Scotland): Psychoanalysis should not be considered the norm nor the optimum child psychiatry and everything else merely a variation from it. Psychoanalysis has a more definite and a more widely advertised theoretical concept, but most child psychiatry utilizes only the normal doctor-patient relationship. It is said that the second stage of child psychoanalysis works best in children with only internal conflicts and no bad environment, but one doesn't find such patients

in ordinary practice.

A Child Guidance Clinic should be more broadly resourceful than a psychoanalytic institution. It should employ a very wide spectrum of disciplines bringing to bear community forces which affect much more of the neighborhood than merely the child and his parents. It should also employ dramatization, placement, education, family therapy, group therapy, play therapy, etc. But very few child guidance clinics are yet this good.

-5-

Discussion by Professor J. B. Boulanger (Montreal): The original child guidance clinic was established in 1905 by the Chicago Courts. It had no possibility of doing child psychoanalysis but developed a dynamic psychiatry which involved a good deal of the community resources.

-6-

Dr. Michael Fordham (London): The Self in Childhood.

This paper clarified a concept of "Self" as different from psychoanalytic ego. The child's concept of self is usually strong though the ego is weak. Organic brain pathology and children's art give many evidences for the existence of self as an entity. (This is not radically different from Sullivanian concepts.)

-7-

Miss Anna Freud (London): A New Classification for Mental Illness in Childhood.

Classification cannot be based on symptoms since they tell little about prognosis or the need for treatment. Besides, children may have few symptoms and show very little suffering in their mental illnesses. Classification cannot be based on disturbance of natural functions because many social functions are poorly developed in the normal child. The key to classification is that the child's most vital psychological function is that of developing progressively. As long as this proceeds the disease is never severe.

Outline of classification ranging from severest to mildest:

(1) Failure of development--from organic trauma, infant deprivation, etc.

(2) Regressions of development--throwing the child back to an earlier stage of adjustment from which he usually can still progress.

(3) Disturbances of single functions such as feeding.

(4) Different rates of growth in different parts of the child's mind.

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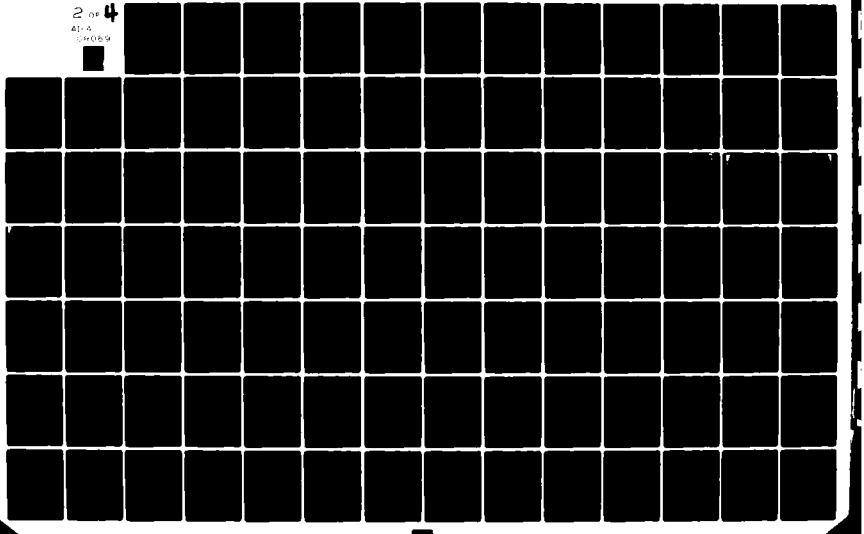

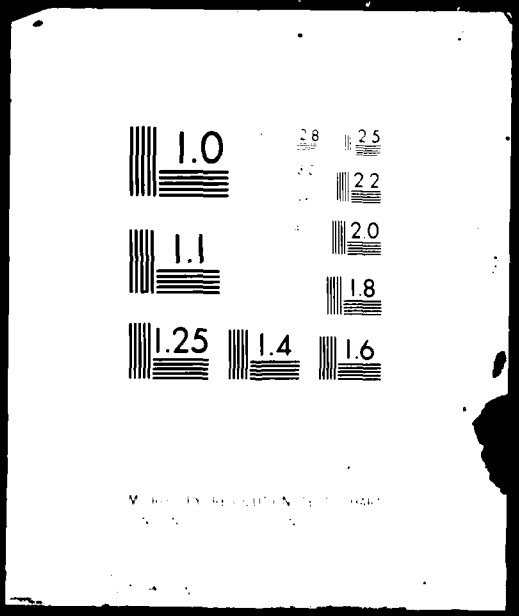

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Discussion: Dr. John Bolland (U.K.): In case it should be thought that Miss Freud is concerned only with the internal dynamics of the individual child, it should be recalled that she participated in discussions of family law at Yale Law School and showed great understanding of the role of the total community in child mental health. Her child clinic's approach now involves a necessary consultation with almost all aspects of community life and management. Especially when that clinic asks the vital question: "Why is this child brought at this time to this clinic by this referral source?" These questions themselves permit a method of classifying and localizing the particular disorder.

With regard to the psychiatrists entering consultatively into the creative work of lawyers, industrialists, military commanders, etc., the question was asked, why clinical psychiatrists and psychologists rather than experimental psychologists should participate. The essential answer was that the best consultative skill here necessitated a personal closeness to pain, sex, feces, effective drugs, family politics, etc., and these things were treated only distantly and in fragments by most laboratories.

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Professor Dr. Annamarie Duehrssen (Berlin): Scientific and Medical-Political Aspects in Child Psychiatry.

A five year follow-up of 150 child psychiatric patients showed with good statistical significance, more favorable results than are found in the average adult treatment. Interesting finding: Children whose mothers did not want them showed more improvement than children whose mothers did want them. The German Child Guidance Clinic is heavily weighted on the side of diagnosis. More real treatment facilities are needed since mere education only makes parents more guilty and mere counselling won't make delinquents honest. Discussion brought out that patients who interrupted treatment were found most frequently among those where the father did not participate. Apparently a second major cause of interrupted treatment was the presentation of new ideas or interpretations to parents at especially traumatic or sensitive times.

WEDNESDAY: The Individual Adult.

-10-

Dr. R. D. Laing (London): Review of the Development of Psychotherapy over the past two decades.

Psychiatry requires a therapist, a patient, a reliable time and place to meet and then it proceeds to peel away all that stands between these two persons--all the carry-over from the past, the transference and counter transference, the lies, the defenses and even some of the culturally imposed prejudices. Lately psychotherapy has focussed more on what has never happened before in patient or therapist. We have asked, "What are the non-transference elements in psychotherapy?" In the therapeutic situation the therapist can now laugh or cry, get up from his chair--even spring surprises, but these techniques are never well written up (see John Rosen and Madame Sechehaye).

There is even a tendency to expect the patient to teach the therapist. The therapist does not merely adjust the patient to his present difficulties but expects him to develop means of continuously managing his own natural world as it changes.

Psychotherapy needs a concept which will help us understand doctor and patient in relation to the social system they are both in. We need to see the ontological organisms as functions of the social organism and this should integrate metapsychology (Federn, Fairbairn) existential psychology (Binswanger, Boss) transactional psychiatry and game theory (Berne, Von Neuman) interpersonal psychiatry (Buber, Sullivan). Metapsychology never placed the individual in any social context; it could not express the meeting of "I with another". The metapsychological ego is only a part of a mental apparatus. How apparatuses interact with each other is unexplained.

Some people think that being sane means being not too aware of the unconscious. Our minds are what the ego is unconscious of. Our minds are conscious of us--not we of them. The dreamer who dreams out dreams knows more of us than we of him. We are out of our mind. If a person becomes more aware of his mind we can't get along with him.

In the view of game theory, it seems that every person has a set of games he has learned to play. If someone else's game meshes with his game then he is compatible--even it there is mutual discomfort. A person whose game breaks the rules of most other people's games must go to the psychiatrist for the ceremony of treatment but his feeling of loss stems from the inability to play the game with anyone--loss of game partner, not loss of the reality of the other person. Behavior of one person is a function of the behavior of others.

Transactions and games can be played as well by machines as by persons. Transaction without transexperience is impersonal. Behavioral therapy and theory is a "schizold" method of manipulation and control because it deals with interaction and communication, but not with pathos or personal experience and feeling. Effective psychotherapy is an obstinate attempt of two people to recover being human. They should discover persons, not exchange objects.

Most good psychotherapists practice inconsistently with their theories. I would rather follow the psychologist into his own experiences than have him decant his experience into a reified theory. The existential thought of a psychotherapeutic process is a flame that constantly melts and recasts its own idiom. It addresses no one except you and me. Therefore, we will never entirely succeed in formulating a theory.

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Discussion: Dr. H. Guntrip (Leeds, England): This discusser was apparently considered an authority on object relations. Essentially he agreed with Dr. Laing and maintained that the psychotherapist was skilled only if he could feel with the patient. For psychotherapy, the Century's most important theoretical change was the shift from concern with instincts to concern with ego. People are trying to develop personal (ego) relations, not object (instinct) relations. For Freud, there was no primary ego. Rather, ego developed after a couple of years of life as a control to instincts. Kleinian Theory now ac-

cepts a rudimental ego at birth which projects its instincts onto other people and then re-introjects those instincts now organized and somewhat personalized.

In the existential concept, life is essentially sad. The encounter is the only important and interesting fact in existence--without it there is no life.

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Dr. Jurgen Ruesch (San Francisco): Psychotherapy for the Well and Psychotherapy for the Ill. Psychotherapy of the mentally well assumes intact sensory apparatus, knowledge of what the communicated symbols refer to, skill to choose a reply, space it properly, observe its impact and then make appropriate adjustments. But most poor communication (especially in the mentally ill) is due to the patient's never having acquired good communication methods in the first place. Therefore, non-verbal communication is necessary in psychotherapy and indeed, 99% of the population doesn't know how to cope skillfully with even verbal interaction. Verbal communication is analgous to digital data-processing or to alphabetic writing. Non-verbal communication is analgous to analogic data-processing--or to ideographic writing, and is more primitive. In any type of disease, skill in non-verbal communication is usually retained longest. Psychotherapists in general are captives in a world of verbal unreality. It is assumed that free associations represent the patient's actual experience and thought. But no-one sees the other fellow's dreams.

Most schools of psychiatry have a vocabulary of a few dozen words to describe processes and diagnoses. With these limited tools the average psychiatrist works. The patient forces self-correction on himself by the impact of his own acts in the therapeutic situation. It is not the psychiatrist who corrects. The psychiatrists usually choose carefully, their methods and their patients. And, as far as personal relations go, they develop therapeutic situations only with the virtually well patients. Non-verbal communication is usually left to nurses, technicians, family, etc. But non-verbal or action-oriented psychiatrists address themselves to sicker patients.

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Discussion: Dr. Medard Boss (Zurich) remarked that the audience popularity of Dr. Ruesch's paper proves the efficacy of verbal communication made at the right moment.

-14-

Professor G. Benedetti (Basel, Switzerland) The Management of Regression in Therapy of Psychoses:

The neurotic regresses to older ways which he thinks he can use to solve his problem (he tries to make his current life the kind of problem with others which he likes to handle).

Psychotic regression is deeper and seeks to use types of communication which are desperately warded off by other parts of the personality, (and also warded off by other people not in collusion with the psychosis). Schizophrenic symptoms are not primarily communications but are autistic.

Id regressions often occur at turning points of life where old ways must be given up--e.g. at puberty, or at the time of starting in the commercial world alone. The problem for doctor and patient is to find a more solid way for adult methods of living to develop.

Super-ego regression: the patient regresses into subservience to a strong super-ego which he has been acting as if he had overcome. The patient turns away from his original goal. The social factor here may be for example, the beginning of an unsatisfactory sexual relation. But, with the regression, this factor is hidden from the patient. There is specific scotomatization of more mature ways of relating which would free the patient from this archaic super-ego.

Ego regression seeks satisfaction in a more primitive social life. The patient narrows his world to very simple and habitual social contributions. It is now only at this primitive level that the patient can experience human relatedness. The therapist, therefore, must meet the patient on this level and not try to appeal to the abandoned adult functions. The regression occurs in the dissociated tendencies (seen by the patient as projections). Thus, childhood homosexual tendencies may return as a fear of being homosexually raped. At first the patient acts superficially as an adult (sweeps the floor, etc.) but he says childish things, masturbates in public and finally lets other adult functions regress. The therapist may do harm here by attempting symbolic realization (Sechehaye). The ego rejects the attempt to fulfill the regressed tendencies on a symbolic level because it doesn't want to be aware of those tendencies. The regression which occurs in therapy is communicative and occurs in a relationship. Pathologic regression does not. A period of difficult behavior which later improves is to be expected in therapy. Such improvement in the ego-regressed psychosis is not expected unless a relationship can be established so that the behavior is occurring in a relationship.

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Dr. Elizabeth Zetel (Cambridge, Massachusetts) Use and Misuse of Psychoanalysis in Psychiatric Training and Psychotherapeutic Practice.

The speaker worked as an eclectic psychiatrist in the Maudsley Hospital and also as a psycho-analyst. Accordingly, she speaks two sorts of psychiatric language. She feels that there are premature attempts afoot to make the two languages and ways of thinking into a single way. This will result in damage to both ways of thinking.

THURSDAY: SMALL GROUPS - Their disorders and Treatment.

-16-

Dr. J. D. Sutherland (Tavistock, London) Review of the Field of Psychotherapy and Small Groups. This speaker explained his subject stepwise, building carefully as he went.

Klein showed that the personality was structured by family interaction which produced in the individual certain introjects (images) of family members and functions.

Talcott Parsons, following G. H. Mead, developed independently of the psycho-analysts, a social concept which is analgous to Klein's concept and applies to groups in place of individuals. Just as a man will manipulate his wife into his unconsciously needed mother-role, so a group will manipulate some individual into a socially-needed role which is just as unconscious to the group.

Personality is a system which maintains its continuity and identity by daily social interaction. Thus the future is a constant reference point affecting behavior. Members of a group have a constant compulsion to cast someone in a role which fulfills a common unconscious need of several members. (They pool their needs in a pre-role exploration. Thus an unoccupied role-slot is created at the concurrence of these needs). A useful member finds some of his own needs fulfilled by the role but sometimes the role will painfully mold the member's behavior. He may resist the coercion--usually ineffectively. He may come to look on the role as his own personality type.

But it takes all kinds of needed roles to make a world--even to make the microcosm of an individual--and if a group is too small there may not be enough role variety available. If a group is too large, projections of needs may get so diffuse that the members cannot feel them as being part of the individual. In group therapy the repressed need systems can be brought out within the group matrix of role sets. A member can then repeat in the here and now, the old conflicts and learn to handle them. Furthermore, the total conflict system may exist by group collusion (as in a family) and treatment may best include the whole group (often within a larger group). The goal of such treatment is to enable the organism to cope with new and changing situations, not merely to overcome an out-dated way of behaving.

The group dynamics and methods of group therapy being uncovered by psychiatry are rapidly being utilized by industrial management. Industry now frequently sends its management personnel to work-group seminars, where different disciplines live, eat, sleep and work closely together for a couple of weeks.

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Discussion: Dr. J. L. Moreno--talked from no notes. He first of all struck a grand audience-encompassing pose and rather quickly captured the listeners--bringing more energetic agreement from then than did any other speaker of the Congress. Essentially he pleaded for research which would be an organic part of group therapy process in ordinary psychiatric practice. One cannot do group therapy without doing group research. Since each group is different, it takes measured investigation to understand it. There are two approaches to group therapy:

(1) Interactional Therapy (or co-actional in sociometric language) which is based on the group process.

(2) Analytic group Therapy based on psycho-analytic investigation of the individual in the group. We need to bring together the two methods-compare psycho-analytic research with action research upon on-going group processes.

-18-

Dorothy Stock Whitaker (University of Chicago and Leeds, England): The Process by which Change occurs and the role of Insight.

This is a study of an 87-session group of 6 members concentrating here on one person's change (Alex).

Assumption: Any individual's behavior arises out of past conflict--a wise and a reactive fear. This therapy group was assumed to be simply one of a chain of situations in life. Alex's wish was to win out sexually against father but his fear of retaliation lead to self-abasement as a chronic solution. Effective therapy made use of a Critical Therapeutic Experience. That is, the patient vividly experienced the wish in group situation but found that the feared consequenced did not occur. The Critical Therapeutic Experience for this one patient occurred in the 62nd session.

Alex presented himself as exhibitionistically abject. The group seemed unconsciously to grasp what Alex really needed. The therapist's presence merely kept the process moving. Here interpretations did not play a role in insight. The group and patient worked this out together.

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Discussion: Dr. Henry Exriel (London). Usually without the therapist's here-and-now interpretations, the patient will avoid really getting the repeated impact of the here-and-now experience. For the patient develops one relation in the group in order to hide another relation. The group disguises its feelings toward the therapist by setting up fantasies and situations which express these feelings covertly. If the therapist does not interpret this, then the group thinks he is only biding his time until the big retaliation.

-20-

Dr. E. K. Schwartz (New York City) Two Views on the Nature of Group Psychotherapy.

This was a moving speaker with a lot of energy but rather defensive concerning his ideas. A dialogue between Dr. Schwartz and Dr. Foulkes laid out most of the concepts.

Dr. Schwartz spoke about groups of 8 to 10 members meeting once or twice a week with alternate sessions where the group met without a therapist. New patients came into the group as old patients left. In a therapy group, the individual is not a replaceable cog as he may be in social or industrial groups. The mission of a therapy group is to improve individual functioning. Group therapy is not individual therapy in front of an audience. It is not merely social therapy without attention to the individual. Changing the society does not revise the individual. Changing the individual does not revise society. The truth is somewhere between these extremes; for group therapy investigates how psycho-sanity and psycho-pathology arise in Man--in both the social and the individual aspects of Man.

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Dr. S. H. Foulkes (London--Maudsley) presented the second half of the above paper. He spoke from an orientation toward group psycho-analysis. Psycho-analysis is biological in origin. It was developed in the dyadic relationship. It is social only for therapeutic purposes. The advantage of group therapy is that the psycho-analyst sees the patient in action with others, better than he can in individual therapy. The relations between group members open up channels to the unconscious which otherwise would remain closed.

Dr. Foulkes rejected fiercely the suggestion by Dr. Schwartz that we should have more tape recordings and movies of group therapists in action--so we can see what they really do, not just what they report. Dr. Foulkes said his private patients would not allow such recording.

-22-

Dr. F. Knobloch (Charles University, Prague) Family Therapy.

Family Therapy is an integral part of a wide system of psycho-therapy in Prague. The family may not be the focus of neurosis in every case but it is always involved in the neurosis. If family group therapy is to be used at all for a patient, then only family group therapy should be used in that case; for such therapy is sufficient to handle the entire problem. Some patients arrive at the clinic aware of their neurosis but not of family problems. Some arrive aware of their family problems but not of individual neurosis. It makes no difference--both kinds can get help from family therapy. The author presented cases to show that many problems could not be helped by individual therapy at all which were rather easily solved by family therapy.

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Dr. H. V. Dicks (Tavistock--London) Family Therapy.

Family therapy was begun as a program in London in 1939. When a family said it wanted to change for the better, it often colluded to maintain an unhappy game--frequently using a child as representative of the idealized (and hated) figures that troubled members in the past. Though many cases began with a child or two in the group, the average case ran for 25 joint or individual sessions with the mother and father. The effect on the child, however, was much greater than on the parents.

FRIDAY: Large Groups.

-24-

Dr. Al Stanton (Boston) Some Therapeutic Mechanisms Arising from Hospital Social Structure.

We are only beginning to examine the "forbidden" in Hospital Society. It is disconcerting us about as much as Freud's examination of the forbidden

in the individual mind. The hospital often denies the patient enough real personal contacts to produce excessive withdrawal, posturing, anger, etc.--behavior which would occur less often outside a hospital. Kahn has found that patient suicides occurred in clusters related to difficulties in staff relations, such as periods when staff members were being transferred. Recognition of some hospital-produced syndromes has helped to decrease the number of patients needing hospital care.

Research Report: A 15-patient ward with 12 attendants for the 24-hour day averaged 1 contact per hour for each patient. Contacts between staff members were twice as frequent as between staff and patient and four times as frequent as between patient and patient. When a patient's interactions with the staff began to increase rapidly, he was soon discharged.

Erickson thinks that personality grows through crisis resolution. Resolution is retarded by the spreading of stimuli through inappropriate channels without forming any hierarchic structure. These channels may be within the psyche or within the society. Crisis resolution is facilitated by a hospital community which is unambiguous and which provides easy interaction, that is, the community which has a well-structured hierarchy with a leveling of human acceptance. Active peer groups with close personal relationships between members most easily resolve conflict between individuals and authority.

The hospital is an organism. Yet, the language used in its analysis has not been psychological but social and managerial.

-25-

Discussion: Dr. J. Cummings (USA) The Value Problem in Therapy.

Values are congruent with social norms. Every act in society is value-influenced. Values, like skills, are learned in human interaction. If an interaction is gratifying, then the self is felt as more valuable; if ungratifying, then the self tends to disdain the part of society in which the interaction occurred. Sometimes the person disdains a part of himself, however, and alters his personal values. This conflict of values may produce a personal crisis. A good therapeutic environment does not protect the patient from crises, but it gives him maximum chance to resolve the crises by a personal change.

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Isabel Menzies (Tavistock--London) Mutual Interactions between Organizations as a defense against anxiety.

Both individuals and organizations are engaged in a lifelong struggle against anxiety. (Anxiety here seemed to mean the incomplete control of certain powerful and real feelings about which one knows that other people have special feelings of their own). Every organization has its own characteristic experiences which produce anxiety, e.g., hospitals have patients die, miners have cave-ins or lay-offs. However, each individual brings to the organization, his own anxiety in the form of anxiety phantasies, arising

out of his past personal life. The individual projects this internal situation onto his present organization. Different individuals project a different internal anxiety onto the shared organizational anxiety. Each individual, therefore, sees the organization differently.

When the method and organization of work is not the most efficient for the task, then this indicates a group maneuver to avoid anxiety, e.g., nurses often set up ward structure so as to avoid much interpersonal contact among nurses and among patients. This "Social Defense System" may detract from patient care. The social defense works, however, only when it is re-incorporated by the individual so that the social defense system becomes a needed "psychic defense system" of the individual. There is a constant unconscious transactional matching of social and individual defense systems. Once the social defense system is well-established it changes little and each new individual must incorporate and use the social defense system as long as he is a member of that organization. This may cause quite a strain on the individual if his personal defense system is much different from the organization's. (Thus, the Army social defense system becomes that of the individual soldier. Men who never defended themselves by certain complaints before joining the Army will make that complaint en masse and bitterly once in a military society where such complaint is the style).

If a social defense system is built on deeply regressed defenses, then new members may find life especially difficult because they must regress to defenses more primitive than those they habitually used. Understanding of the social defense system is important in diagnosing organizational difficulties.

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Discussion: Miss D. Weddell (UK)

A key member's anxiety can influence the society's defense system. Example: On a night shift, many patients needed the nurse in the middle of the night. They demanded drugs, food, etc. It was found that the nurse needed to be needed thus. A new nurse said, "I am going to bed at the same time as the patients. Patients can get food for themselves if they really need it. I am available mainly for emergencies". The demands of the patients ceased abruptly.

-28-

Professor C. Mertens de Wilmars, (Louvain, Belgium) Intervention in Organizations.

Intervention of behavioral science in organizations is called Sociotherapy. It modifies the model and the culture of the group and thus produces a new system of inter-dependent relation among group members. Maturation is not only an individual process but it occurs also in group inter-relational experiences. An individual's understanding of the group's perception of an object gives him greater security than his individual perception alone. (In a civilized individual it is questionable whether there is any purely individual perception. There is only individual understanding of a group's way of perceiving. Security comes from the individual's understanding of what his present group's perception is. Thus, if he is living in the Army, but perceiving entirely in the manner of his childhood family group, he may be insecure).

Conditions regulating change in organizations:

(1) Identification (ultimately projecting and introjecting) lies at the base of all personal or organizational change.

(2) Experience of the effect of social forces (approval, disapproval, blinding, etc.) upon the individual determines how thought associations will flow. Operant conditioning experiments have shown it is social approval which modifies behavior and, to a large extent, regulates perception of any object or problem.

(3) Introspection stabilizes the effect of change. But insight and introspection alone do not produce the change. An organization is a functional system of exchanging information. Modification of the organization's way of exchanging information produces a change in the organization.

Classes of intervention by the Sociotherapist:

(1) Indirect intervention modifies the environment or key persons with whom the organization must work.

(2) Direct intervention changes the total organization's internal structure.

(3) Allo-centered intervention alters the content of interaction. (Changes what the members say or do).

(4) Auto-centered intervention alters the inter-relations between members of the group.

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Discussion: Mr. Eric Trist (Tavistock, London) The need to influence wider networks.

Without prior discovery of the principles of individual psychiatry and psychology, we should not have been able to develop Sociotherapy and the Therapeutic community as we have them today. Psychiatry can make general contributions to:

(1) The making of general hospitals into true therapeutic communities from the human relations point of view.

(2) The rehabilitation of millions who will be automated out of a productive role.

(3) Population control in developing Countries.

The Harvard School of Public Health has developed Mental Health Teams which deal with social problems. Psychiatrists can be useful on all teams which help to mobilize human resources.

Some specific problems Psychiatry should face are:

(1) The problem of improving the effectiveness of people who will never bring their difficulties to a Psychiatrist.

(2) The problem of helping the segments of population which are undergoing turbulent social change.

(3) The conflict between the creativity of rising new professional people and their relatively static professional organizations. Invitations at present, for experts to assist in organizational change are very scarce.

(Further discussion revealed examples of the successful use of Psychiatrists as consultants to productive organizations including the Tavistock Institute's work with British industry and the human relations consultants presently employed in developing Norwegian industry.

(Dr. Maxwell Jones and his colleagues in another discussion, wondered if individual psychiatry has not impeded the development of Sociotherapy by causing most talented psychiatrists to become so invested in individual theory that they can only see groups in terms of that individual theory. Much of the newer psychic theory is being developed by Sociologists, Economists and Mathematicians who are committed to the group as the significant organism. If psychiatrists are going to maintain tunnel vision by seeing groups only through the eyes of individual psychiatry, then helpful clinical group theory may be crippled. Maxwell Jones, therefore, considered training his new therapists from among men with a basic education in Archaeology or Economics rather than medicine. Thus, their psychiatry can be, from the first, group psychiatry and they can see the individual in terms of groups--not vice versa.

(There was also recall of Tass's accusations that American Psychiatrists were associated with the "Scientist Generals" who were converting technology into an economic boom by developing the "Warfare State". This seems to indicate that Russia's own concept was to employ Psychiatrists in economic and military planning and if so, they are ahead of us in thought).

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Dr. David Clark (Cambridge, England) The Developing Concept of the Therapeutic Community.

The original working concept of the hospital was that the nurses "contain" the patients while the doctors come in occasionally and treat them with chemical or physical medicine. In World War II it was discovered that hospitals can be an evil influence on the patient--prolonging or even creating morbidity. Later, some new ways were discovered of providing good influence on patients. (Cf Dr. Thomas Main on the Northfield Hospital as a therapeutic community in Bulletin Meninger Clinic 1946). A hospital is an organization whose members consist of Staff and Patients. Every member participates in a community effort to make disturbed patients more capable of living in a normal society. (Here there was brief discussion of the work of William Caudill in the US Army, of the milieu wards at Walter Reed General Hospital, and of the studies of Stanton and Schwartz at Chestnut Lodge).

The majority of British psychiatric patients are under no legal restriction and are not in locked buildings. The hospital is now, more than ever before, similar to the community to which the patient will return. Hospital meetings now frequently include all the Staff (doctors, patients, janitors, etc.) and there is a corrective learning experience for all. If

individual therapy is to be used, it should be provided for nearly every one in the therapeutic community and not just for a favored few.

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Discussion: Professor Warren Dunham (Wayne University, U.S.A.)

With the greater democratization of business management in recent years, the therapeutic community has found its concurrent parallel in industry. Many businesses and schools have gotten away from strict authoritarianism. A therapeutic community best develops with a completely new staff, trained in the new ways--the non-authoritatian but group-oriented ways. Otherwise, there is wasteful conflict between the old and the new. Construction of therapeutic communities is giving us data on how far we can go in constructing other sorts of artificial societies. We should not set up a therapeutic community which is so good that patients cannot realize a comparable degree of good relations in their home community. We must be sure we are adapting our patients to the natural community to which they will return.

(Perhaps the best way to adapt "Hospital" patients to their own natural community, is to make the hospital a more closely related part of that natural community).

SELECTED PAPERS FROM THE VARIOUS AFTERNOON SESSIONS

-32-

Dr. Roger Shapiro (NIMH Bethesda, Maryland) The Origin of Adolescent Disturbances in the Family and in Infantile Development.

The young child must withdraw his rather complete emotional attachment from his parents and put it on other things. Thus he develops an ego identity, a sense of autonomous-self. He is able concurrently to reassess his parents (Piaget). Society outside the family helps him make this emotional pull-away from parental dependency. One's definition of self is related to society's definition of that self. Altered social definition at puberty, for instance, produces changes in the personality.

The National Institutes of Mental Health investigated the family-patient definitions and emotional pressures as they bore upon a child's psychosis. There was little investigation, however, of school-patient or social group-patient systems. This study concerned adolescents with psychosis or severe emotional breaks occurring the first year of college, in the first prolonged separation from family. Participation of the entire family was required. Individual psychologic assessment was made as well as systematic observation of the family group in action.

A "delineation" is the image one person has of a second as revealed in the behavior of the first person toward the second. Delineation is used by a group to bring about a redefinition of a member's personality to suit the needs of the delineators. Study of the styles of parental response to signs of the child's development revealed defensive "delineation" on the part of the parents. The child's personality-pervasive symptoms were related to circumscribed disturbances in the parent. The child sometimes developed a psychosis related in style and extent to the disturbance in the mother-father relationship. It seemed that current family relations were less understood than the historical relations but they had a more important effect.

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Dr. John H. Howells (Ipswich, England). Family Group Therapy

The family can best be helped by putting the greater part of the therapist's attention on the community. Then the therapist can best formulate the family's position in the community and understand the family's present needs and possibilities. The symptom is part of the patient, just as the patient is of the family and the family is of the community.

(The question was raised as to whether symptoms always belong to an individual? Workers who concern themselves primarily with families and communities find that symptoms are quite capable of moving in their entirety from one family member to another and even on to another family).

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Dr. Stephen Fleck (Yale University) Indications for Family Psycho-Therapy.

The family is the crucial link between the individual and the national culture. Family provides the acculturation which makes him a human person as our culture understands the word "person". To be useful in society, the individual must deal with the community. Therefore, the interface between family and community is as crucial as that between individual and family. The essence of all family therapy is the promotion of communication among family members.

Study of families with one member hospitalized revealed that most families containing one schizophrenic member had an unusual relationship to the community--just as the schizophrenic member had an unusual relationship to other people. If the therapist understands the family language, he can obtain a better history from the family than from the patient himself. Some member of the family will spill the history for the others--acting as the mouthpiece even though other members may pretend they do not wish him to. (The patient's history is often but a puzzle-piece of family history though it seems to stand complete in itself).

Types of families:

(1) The homeostatic family resists treatment and retains its painful life in equilibrium, holding the sick member in the family. If a member of this family is hospitalized, the hospital usually looks on the family as a nuisance and the patient is easily forgotten too. If the patient is hospitalized for a long time, the family reorganizes around a new equilibrium which does not permit re-introduction of the patient. (Industrial and military units who lose a member also tend to orient themselves around the work and close out the patient).

(2) The ejecting family tries to solve its troubles by pushing the patient out of the family and onto some institution.

(3) The scapegoating family retains the patient in order to blame him for difficulties which would otherwise fall to the responsibility of other members.

Once therapy is begun with the family of a hospitalized patient, it must be continued until the patient is integrated into the community. He can only be naturally and effectively introduced into the community through

the family--not through "halfway-houses". Family therapy is most effective when managed by a therapist who is not connected with a hospital or when no family member is hospitalized. The vertical and horizontal status and communication barriers in a hospital prevent close work with a family. Some day such hospital work may be possible when hospital staffs themselves really work like good families.

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R. D. Scott (St. Albans, Herts, England). (paper concerning family history through the generations).

Since many English families are rooted for a couple of centuries in the same community, it has been possible to study the history of the long generative line much better than in America (Americans assume there is no such thing as influence from great grandparents). For instance, the double-bind concept has not been formulated as a process with much time depth. In English families, a member is often felt to be especially like a psychotic ancestor, called a "shadow parent". The family member apparently plays the traditional role needed by the family, generation after generation.

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Dr. A. Ferreira (San Jose, California) Family Myths.

When I did individual psychotherapy I often asked myself, "What makes my patients so very sick?" When I began family therapy I marvelled that they were so well.

The patient's symptomatology is an indication of the way his family has been relating. No man behaves purely as an individual, but rather as part of a relationship of some sort. A very frequent family problem presented, is that of a child who is trying to change. The parents come to the clinic, hoping the doctor will help maintain the status quo. In other words, they assume that the child must be sick and they want the doctor to confirm this so that the general social attitude toward this "sick" member will force him to conform, or at least will relieve the family from having to change.

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Dr. Manfred Lindner (Nurnberg, Germany). Result of a Social Experiment in Larval Group Therapy.

Patients, after individual therapy, were put into a group along with some non-patients. Goal: More understanding of self and of other people. The same group continued for 10 years (apparently with between 10 and 20 members). New members constantly joined as old ones left. At first, largely male, the group became about half women as new members brought their wives in with them. Single men shrank in importance when couples appeared. The group eventually outgrew its therapeutic work and founded a dance, wandering and bowling club which became essentially a society for the study of modern living. The interest in discussion lapsed, but the society formed still flourishes. The neurotic members of the original group found easy social life in the total community as well as in the group. In the course of time, identification with the group leader was no longer necessary.

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Mme. Feya Reggio (Vanves, Seine, France). A Psycho-Sociologic Technique of Changing Social Comportment.

"Normal" people who desire to change habitual ways meet a total of 3-one-hour sessions in groups of 8 to 15 members. The co-therapists are, a male psychiatrist and a female psychologic-sociologist. Members talk about their own present feelings and behavior and are urged to express all their feeling concerning the therapists. Both verbal and silent expressions are recognized. Therapist's interpretations refer only to the group and never to individuals, e.g., there is interpretation of the manner in which the group divides itself into male and female camps. (A single member's attack on a therapist may be interpreted as a group attack if no other members have opposed it).

The groups nearly always bring out struggles in power relationships and in sexual relationships. Usually the two struggles are closely juxtaposed. The individual love for power is frustrated in group interaction, but group relations become a compensation for lack of personal power development. The psycho-sociologist views relations most frequently as social power struggles, while the psychiatrist views them mostly as sexual power struggles.

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Dr. Julius Guild (Edmonton, Alberta) Group Techniques for Training in Psychotherapy.

Often Social Workers and other ancillary personnel are as good at psychotherapy as psychiatrists are. Group methods allow them to obtain the self-knowledge necessary for the best psychotherapy; for the group process sensitizes the student to his effect on others and their effect on his own thinking and feeling.

A group of eight trainees met weekly for two years. After one year, half the members left voluntarily and another half was taken in. The verbal group interaction was very slow at first. Everyone seemed reluctant to reveal much about himself, probably because of the close association of colleagues in the small city. Knowledge of psycho-dynamics seemingly made people guarded lest the worst interpretation be placed on their productions. The leader was the only psychiatrist present, but he also had close social relations with the other members.

Group supervision of taped interviews between patients and members amounted to a naked exposure of the member of the group.

The group was called a "group process group" because it definitely was not a therapy group. The members, in their talk about relations to authority, seemed equal in maturity to adolescent girls. But the general result seemed to be that the members developed better relations with their patients and co-workers.

This group process group seemed related to the type of group used as "Sensitivity Training" in U.S. industry (Cf) Chris Argyris). In Sensitivity Training, groups with 7 to 10 members meet 2 hours at a time, 2 or 3 times a day for 10 to 14 days. At the end of each day, 2 or 3 small groups form a

large group. The staff tries to illustrate the emerging group processes. There is no agenda, no format, no procedure, no tradition. The conventional methods normally used to deal with other people fall flat. Members get no help from the Staff and therefore they have to gain trust in each other. They see how personal needs effect group decisions and perhaps how group needs effect personal decisions. Members return to their industries warmer and more sympathetic, but as some work continues to impose authoritarian problems, many members relapse.

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Dr. Elizabeth Shoenberg (London). Planned Use of Split Transferrence in a Mental Hospital Admission Unit.

The conclusion here was that the emotional substitution of 2 or more therapists for significant persons in the patient's past can yield a therapeutic result greater than the sum derived from the 2 separate relationships.

In a hospital's therapeutic community, patients obtained therapeutic effects from groups, individuals and family, but on discharge they were only told to go to the out-patient clinic and relate to 1 social worker. Since many patients returned to the hospital, patient groups were created outside the hospital to continue a therapeutic effect more akin to that in the hospital itself. It appears now that patients discharged from therapeutic communities get along better in society than the same patient does when discharged from a traditional mental hospital. He is very attuned to getting along in groups. He obtains some security by returning to the hospital just to look around or to join temporarily in some group. The difficulty is that therapeutic communities employ so much verbalization and so much smart role-playing in groups that dullards can't utilize it.

In discussing this paper, the responders from England avoided discussion of community leaders (parents, bosses, ministers, mayors, policemen, etc.) as co-responsible in changing behavior. It was as if the medical profession wanted to corner the behavior market. No one thought of helping the natural working, playing, managing, praying community to accept and responsibly to guide the patient. However, Mrs. Roberta Glick, a social worker from Hillside Hospital, New York presented a paper on "Differential Use of Groups in Development of a Milieu Therapy Program" which discussed the use of Civic organizations and leaders in dealing with patients and groups of patients in the New York City area.

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Dr. E. Hardke (University of Indiana). Preventive Psychotherapy.

A significant fraction of the work of many psychiatrists now deals with the improvement or maintenance of mental health rather than the fighting of mental disease. In May 1964, the APA amended its constitution to include as an aim, the promotion of mental health.

One application of this preventive work was the "Anticipatory Guidance" in Peace Corps training. Since 1961 there have been a total of 250 psychiatrists involved in Peace Corps training. Success of psychiatry was calculated in terms of the maintenance of group mental health in normal trainees, even after they had gone overseas and left the psychiatrist. There was about one psychiatrist to every 50 trainees and each trainee received 5 hours of mental health instruction. Essentially the psychiatrist gave

forewarning and anticipatory practice in the group and individual feelings arising from overseas stress -

(1) Peace Corps volunteers were put into 10 or 15-member groups and encouraged to ventilate feelings about their present life in the training situation.

(2) Volunteers ate a meal of the sort eaten in the overseas country and under the overseas rules of behavior.

(3) Volunteers experienced tropical life and climate during a few weeks special training in Puerto Rico.

(4) Volunteers were told that depression was common after 3 or 4 months' overseas when initial enthusiasm wore off and common again at 12 months when it became evident that the volunteer was not going to have as much effect on his little overseas world as he had thought.

Change in self-image is common among the volunteers overseas. Some small notion of the shock of this change is given in training. About one half of the volunteers who returned prematurely, came back because of depression. These depressions, however, constituted only 1% of the total number of volunteers in service.

(Discussion: In the summer of 1964 there were 5000 Peace Corps volunteers in training with 117 psychiatrists. Since most of these psychiatrists maintain a bread-and-butter dedication to one-to-one psychotherapy, only a few of them saw that a fundamental change in orientation was involved when they practiced upon improving mental health rather than battled against mental disease. The great vocational gratification could no longer come from making a spectacular diagnosis or caring for an extremely sick patient. Considerable curiosity must be devoted toward social groups and toward the needs of the community, not merely toward the psychic depths of the individual).

Four co-workers from Henderson Hospital, Dr. Maxwell Jones' original Therapeutic Community near London presented the four following related papers which were discussed by part of the audience which was involved in therapeutic communities.

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Dr. F. H. Taylor (London). Group Methods for selection of admissions to a Therapeutic Community.

The patients in this hospital are nearly all severe character disorders. Most have served prison sentences. The patient body elects a 9-man committee to screen applicants for admission. Six or eight of the hospital staff sit in, and six or eight patients are seen at one time for a total group of nearly 20. Except for the doctor's physical examination, there is no individual interviewing but only group interviewing of these candidates. The patient members of the hospital are very sensitive to which candidates are well-motivated and how difficult their treatment will be. The staff does the official admitting but the patient's wishes usually prevail. About one-third of the applicants are accepted. This selection theory and its attitude toward patients contributes to the strength of the therapeutic process within the hospital.

Dr. F. Stallard (London). Controls in a Therapeutic Community.

Most deviant behavior is regulated by the patients themselves. The hospital officially tolerates more widely deviant behavior than the town communities pretend to tolerate. Nevertheless, the patients well understand the firm limits on behavior.

Patient groups have a chairman, a vice-chairman and a lady-vice-chairman. Several other elective group roles are set up--including custodial roles. Since daily group therapy is essentially the only psychotherapy here, the patients are quite used to group interaction. Whenever there is a crisis in behavior, an emergency group meeting is called and the whole matter is dragged out and discussed, even if it is 3 o'clock in the morning.

The patients are more loyal to their own group roles than to the persons who stand in transference relationships. For instance, a group chairman surprised himself by acting responsibly toward a woman patient who tried to seduce him sexually and masochistically. Yet, formerly, he was very susceptible to such deviant practices. In group roles, patients are given responsibilities they never had before and they come thus to change themselves. A poor worker may be put into a responsible job so that he can develop therapeutically in the living-learning situation.

Miss Elizabeth Barnes (Matron) (London). Role and Training of Nurses in Group Therapy.

No patient group operates independently or in isolation. All are related to other groups. All are concerned partly with administration, with establishing rules and codes of behavior as well as with therapy. Patients share administrative responsibility with the nurses. (Essentially they collect data for the groups and write what in other hospitals would be considered part of the nurse's notes). A patient who becomes physically sick and goes to bed, is out of the group and out of therapy. Each new professional worker usually thinks he is the good therapist for a particular patient. This professional then tends to estrange himself from the staff and to get on the side of the patients. If these new staff members feel that the concepts of the therapeutic community militate against their maintaining their own self-concepts then these members identify with patients too closely for their own safety. The problem is to teach these staff members to share patients with each other and with other patients and to realize that treatment comes from understanding and working with the total social situation and from seeing how each member is linked into that situation. Nurses who cannot learn this are sent to surgery or to "Janitorial" type of work. Patients may nevertheless challenge these nurses and thus push them for self-help back to the group community.

Mrs. Gillian Parker (Miss Gill Elles) (Psychoanalyst, London). Family Treatment in a Therapeutic Community.

Very disturbed families hate to see one member get a great deal more treatment than another. This situation can be analyzed in a family group and sometimes must be extended to include non-family members. For the illness cannot be adequately dealt with if considered to exist in only one person.

Sometimes, however, the first patient wants help for a second person's real disturbance and this help through another member may be the only way the second person can accept help.

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Dr. Maxwell Jones (Melrose, Scotland). Training of the Social Psychiatrist

A decade ago we thought that when we made a diagnosis by concentrating on an individual patient, then certain treatment and management events would naturally follow. Nowadays, we are not even sure what is a "case". Does "case" include staff and patient, family and patient, industry and patient, political structure and patient? (High-powered university medical talent is only lately coming upon a problem and a concept which was necessarily managed by small communities for many decades past). Some small town public health doctors and other community workers have been angry at their psychiatric consultants because the small town workers feel that they themselves had long ago discovered social psychiatry.

To alleviate the problem of the young doctor who is too narrowly steeped in medicine, some universities give a double degree in Social Science and Medicine. Certainly a traditional medical education dedicates the graduates so inflexibly toward the one-to-one doctor-patient relationship and toward the traditional hospital as the citadel where doctors practice upon disease, that few graduates even interest themselves:

(1) In public health rather than in private or hospital practice.
(2) In preventing disease and improving health rather than in fighting disease after it develops.
(3) In working with groups where the doctor is a member rather than developing only a private relationship where the doctor is an insulated authority.

In order to work in a therapeutic community a doctor has to step even further from old concepts, "I would prefer to take as a student in Social Psychiatry a graduate in Archeology rather than one in medicine. At least the Archeologist doesn't have to undo so many concepts".

The ward group meeting is a training medium. Some groups include staff and patients, some only staff. In a way similar to the no-agenda "Sensitivity training" of industrialists, each person in the group becomes aware of the way he interacts with others, the way others see him, and the way he best uses his personal resources. This is called a living-learning situation and it eliminates most of the need for didactic training. The process of the developing ward-history can be stopped at this point and examined by the group. For example, if a nurse is in love with a patient, then the group can examine how this came about and what its meaning is within the context of group life. The resident together with his supervisor is confronted every day by his own behavior in the group. The entering patient and his family can be examined by the team of patients and staff which will be living with him. The group can watch the interaction between the patient and his family as the group, eats with them, plays with them, etc. This sort of life makes the social psychiatry resident more aware of the group influences upon him and more skillful at appropriately managing the personal and community history which he can influence.

COMMENT BY: Dr. Bob Rappaport (Social Anthropologist, Boston).

Social Science field work should be added to this training of the Social Psychiatrist. The resident should not merely m ake domicilary visits where he is regarded as a professional from another social echelon, but he should interview normal couples getting married, participate in funerals, classrooms, industrial work rooms, etc. Training in social psychiatry cannot be met by books and classes. It must be an experiential thing just as psychoanalysis is, or as a T-Group at Bethel, Main. Part of the resident's training is training as a patient.

SOME CONCEPTS OF MILITARY PSYCHIATRY

by
Lt Col Matthew D. Parrish, U.S.A.

(Lecture Delivered at Annual Norwegian Armed Forces Medical Meeting, Oslo, Dec 1964)

Here I shall review the essentials of military psychiatry in combat and in garrison life and then I'll present some social psychiatric concepts as a way of explaining the techniques. I don't mean to say these are the only ways of looking at the work of the military psychiatrist nor are they necessarily official US Army methods.

The incidence of chronic psychosis is about 2 cases per 1000 population per year--in combat or business, in Tahiti or Tennessee. The increased stress in combat which brings on physical casualties also increases mental non-effectiveness--although there is no increase in chronic psychosis. The psychiatric incidence is about 30% of the total casualties. This non-effectiveness may take the form of temporary breaks with reality which imitate some of the usual psychoses, or they may be severe neurotic impairment of emotions and intellect. The important thing is that about 90% of these casualties, if properly handled, near the area where they occurred, recover in 2 or 3 days.

The military importance of psychiatry thus lies in the fact that there is no other large block of casualties which can recover so quickly. In conventional warfare, orthopedic casualties also account for a large fraction of the total, but orthopedic casualties seldom return to the same battle. Their handling, therefore, has less effect on the battle than the handling of psychiatric casualties.

The technique of combat psychiatry usually consists of (1) Temporary relief from the immediate stress of combat (2) warm food (3) a bath (4) sleep (perhaps with a sedative) (5) abreaction--letting the patient spill out some of his feelings to a medic if it seems appropriate (6) expectancy that the casualty will soon return to his normal unit. Sometimes a short relief from stress alone is enough. A corpsman with the company may lead a mute "catatonic" soldier back to a shell-hole and say "You rest here, Charlie, and I'll take you back to the front line in an hour". If the corpsman is wise, Charlie will return to the line effectively. Yet, the average hospital psychiatrist might have considered Charlie a chronic illness requiring long-time treatment in Walter Reed Hospital.

Food, bath, sleep and sometimes the release of feelings amounts to a controlled regression. We all have a daytime alertness and a weight of responsibility which regresses at night to more relaxed and even childish feelings, at which time we are concerned with feeding, bathing and curling up in sleep. This relapse at the end of day, with the expectation of freshness in the morning, makes us work more effectively. This seems analogous to the rhythm of fight and rest in combat. If the stress of fighting is severe, then a soldier may need to follow it with a profound temporary regression. The medical corps makes sure this rest occurs in an atmosphere of expectancy toward quick return to full responsibility.

This expectancy is maintained in the division clearing area by keeping the patients in tents in their normal uniforms, continuing physical training in a military manner and keeping no one away from the battle-front more than 3 days. Thus, new patients find that the old patients are saying "Joe went back to the Company yesterday, I'm going back tomorrow, you will come back the next day". Even those few patients whom the psychiatrist feels must go to the rear often ride out of the clearing area on the road to the battle line and only later turn aside.

Many psychiatric casualties are managed by the brief techniques possible on the battle line itself. Many others are returned forward after a trip to the battalion aid station. Still others require the 2 or 3 day treatment at the division clearing area. In all, about 90% are returned forward by the end of 3 days.

Those patients evacuated to hospitals out of the division area suddenly feel they are no longer responsible members of the units around them. They feel guilty at having abandoned the combat company where they may have formed the closest ties of their adult life. They must be sick now, or the guilt will be severe. They quickly adapt to the role of rear echelon patient and only about 10% of these ever return to the front. As far as winning the battle is concerned, one division psychiatrist is more important than many hospital psychiatrists.

* * *

Now let us look at two possible concepts which can underlie the technique of military psychiatry. One concept is from an individual and the other from a social point of view. The former is perhaps older and it maintains the concept that, the disease is inside the patient. It is considered first that the patient is reacting violently to some germ inside him or to some derangement of his organs or inner thoughts. Whoever administers the proper drug or physical manipulation will cure the patient of the disease. Furthermore, if a patient with undesirable behavior is eliminated, the behavior (under this concept) is eliminated also.

Some military psychiatrists feel, however, that they are more effective if they use a rather newer concept. To wit: Disease is an interplay of many vectors within a social organism.

Thus, a house visitor may fall down the stairs and break his leg. Under the old concept, the disease is a derangement of his tibia to which the body reacts with pain, dysfunction, etc. Under the new concept, the doctor questions whether the visitor may have been depressed by his relations with others and did not really care at the moment whether he fell; or perhaps he had a need to show off carelessly. Did other people fall in previous months, and the family in the house fail to remedy the trouble? Are family members trying to show each other something by this neglect? Did the carpenter who built the stairs feel that nobody cared enough how he built them? This is a possible plexus of social group pressures which ask for an accident to happen. There are also factors which influence the rate of the broken leg's

recovery, e.g. (1) the patient's desire or lack of desire to get back to work (2) someone else's guilty feeling that it was all his fault (3) a possible need of the hospital staff to nurse this patient along and make the staff feel more needed (4) the degree of alertness or carelessness among nurses which grows out of their relations to each other.....

This social concept is concerned as much with prevention as with treatment. It is concerned with the total welfare of a group and not purely of an individual. It is not only concerned with who has the symptom, but with why this symptom occurs in this unit at this time. In America, doctors long ago began to consider the patient as a whole and not just his broken member. But as yet only a few specialists really concentrate on the local community (or company) as a whole and not just on one of its members.

In psychiatry we often find that the social group needs one of its members to fail. Failure may, for instance, show the boss he is "working us too hard". One member of the group may be the most susceptible to group needs and pressure. One member may be the most susceptible to a certain symptom which is appropriate to the needs of the moment. So, if AWOL will demonstrate something of importance, we may have AWOL's, but they may occur in the member who has a history of school truancy. A Company may expect that it will be the ex-boxer who finally strikes a generally disliked Sergeant. This expectation makes it more likely that the boxer will be the delinquent here.

To eliminate such a patient then, does not eliminate the society's need to communicate its problems. The patient becomes a message. The company becomes an organism with a need to communicate a message. The doctor becomes a labeler of messages. He stamps the patient with the name of a disease. The patient becomes a recognized symbol--a significant message.

* * *

Military psychiatry techniques may be described in terms of these social principles thus: (1) the doctor fits the patient out with a label which means "He is like all of us", that is, the patient is exhausted, angry, afraid, but not diseased, beserk or phobic. For this reason the psychiatrist will use a term like "combat exhaustion" rather than "shell-shock". (2) the doctor lets it become known that the prognosis is good, that the patient soon will be functioning well and in his natural group. (3) the doctor allows temporary regression--food, bath, sleep, expression of disturbing feelings--in a familiar military setting near the front. (4) the treatment is by group pressure arranged as if prognosis were good, for example, the patient sees everyone else returning forward. (5) the psychiatrist tries to satisfy the unit and the patient by appropriate understanding and appreciation of their work and needs. For neither "diseases" nor "messages" can be permanently changed unless there is some management of the needs which produced them. Such appreciation and management is effective when coming from division staff officers who are not really members of the fighting company itself, but are close enough to the problem that the company can see that they feel it personally. To eliminate the symptomatic patient himself or to cure the symptom within a patient will not prevent further symptoms in a unit which needs to produce them.

How can these techniques be used for prevention as well as treatment, in peace as well as war? In these situations the military psychiatrist attempts to carry out the following: (1) the psychiatrist has regular conferences with the first echelon physician (Battalion surgeon) and with the medical corpsmen supporting that echelon. (2) the psychiatrist, social work officer and the accompanying technicians consult commanders upon human relations problems. This consultation is best carried out at the unit itself, for there the consultant sees the problem in situ. He sees not only the patient-complaint but the group surrounding him. Both evaluation and treatment of the complaint is often obtained best in a squad interview. Here, the patient is seen in the company of those he works and lives with most closely. Dr. THAULOV, of the Norwegian Navy, has developed a very interesting method of his own along these lines. Such a method allows the psychiatrist to get hold of the causes of the "patient-symptom" and to help command to manage the whole situation. (3) the psychiatrist keeps a chart on every unit which produces a patient-symptom. Thus he can most easily see the trends in his own work with these units as well as the sort of symptom the unit produces. (4) To get a better understanding of the unit, many psychiatrists follow the rates of delinquency, accidents, etc., but they usually find it wise to avoid concentrating on the lowering of a certain rate. For, we may prevent delinquency only to increase sick-call, or vice versa. (5) When groups and their natural symptoms are well-understood, then the group behavior of a member can be of prognostic value in personnel selection for routine duty. Thus, we might eliminate a man who succumbs to playing roles which are but little needed in the group or a man who cannot commit himself to any group responsibility. Who these men will be is usually better determined by a trial of real duty than by tests given at a time when the men had no appropriate emotional committment to military life.

In Summary then, I have tried to show how the psychiatrist's work with the military unit and its command can be effective in prevention and treatment of psychiatric non-effectiveness.

11/1/73

MEDICAL ASPECTS OF LEPROSY

By Matthew D. Parrish, M.D.

Reference: Dr. R. G. Cochrane, 57-A Wimpole Street, London W-1 (age 65 in July, 1965).

Chaplain Osborne E. Scott, LTC USA Ret., American Leprosy Mission, 297 Park Avenue, NYC 10010.

Natural Course of the Disease

1. All leprosy begins as Mycobacterium leprae invasion of Schwann cells in the peripheral nerve sheaths. Consequently the first symptom is anesthesia. M. leprae can grow only where there is decreased lysosome, and normally, lysosome is plentiful in Schwann cells. Possibly a low level is genetically determined. Leprosy ends anatomically, and multiple sclerosis begins where the Schwann cells end and the oligodendrocytes begin--in the central nervous system.

2. After one to seven years M. leprae breaks out of Schwann cells, macrophages get hold of it and produce tissue reaction extraneous to the Schwann cells--eventually in the reticulo endothelial system (spleen, lymph nodes, liver...). These reactions produce:

(a) Tuberculomatous leprosy--self-contained nodules which probably will get better by themselves without treatment.

(b) Lepromatous lesions, which are less well delineated, more reactive, and disseminate easily.

(c) Dimorphic lesions--both (a) and (b) together.

3. An auto-allergic reaction of an amyloid type may occur in the reticulo endothelial system to the products of M. leprae--to little pieces of inflammatory reaction of the M. leprae organism itself. This extensive reaction may produce death, and is most prevalent in Caucasians.

Signs and Symptoms

1. Anesthesia is always the first symptom. It occurs on buttocks, forehead, hands, etc.--occurring in places where there is prolonged rubbing contact with infected persons. The average case has anesthesia for seven years before the diagnosis of leprosy is made.

2. Hypo-pigmented macules, with well-defined edges.

3. --or many scattered macules and patches with rough edges.

4. Raised patches:

(a) Saucer shaped, active at the edges (lepromatous);
(b) Inverted saucer shaped, active at the center (tuberculomatous).

5. Loss of hair and eyebrows.

6. --All symptoms and signs depend on the geography, race, and genetics, but anesthesia is always first.

7. In the human species, the most common cause of anesthesia is leprosy, the most common cause of claw hand is leprosy.

Treatment

1. While lesions are inflammatory no treatment is indicated. If inflammation is too severe, cortisone is a palliative.

2. In more quiescent stages treatment is sulfones (DDS) from 1.5 mg. to 30 mgs. per week. More than 30 mgs. per week may decrease lysosome activity, and therefore may stimulate development of the disease. M. leprae does not become resistant to the sulfones. It's just that too much sulfone results in increased M. leprae.

3. The patient may have to be maintained on sulfones for life.

Distribution

1. Ninety nine percent of the people in the world are totally immune, no matter how much contact they have with M. leprae.

2. Most of the one percent who get it contract it by prolonged contact, for instance, the baby's head rubbing against the African mother's back as she carries him. Or the Asian mother's contact with the child's buttocks.

3. Some of the one percent have contracted the disease with one small inoculation. It has been contracted from a tattoo needle.

4. Leprosy is largely confined to the tropics, at the borders between primitive and more modern civilizations. Pygmies, for instance, never had it until they recently began to work for more "advanced" people. No aboriginal people have the disease.

Some Public Health Problems

1. The public considers leprosy a rare disease of filth. Therefore, it does not support research. It is better to deny that leprosy exists, and thus avoid emotional contact with it altogether than to concede that "I could get it" and therefore produce the emotional energy to prevent further cases. After all, we have only so much emotional energy and we need to put some into preventing crime, some into preventing mental illness, dropouts, polio, cancer, war... We just have to isolate the battlefield by denying the existence of some of the enemy forces.

2. In 1965 there were about 350 patients in Carville, Louisiana. Only 100 needed to be there for their leprosy. 250 had "hospitalitis" and couldn't get out into the world. This is as true of most leprosariums as it is of other chronic sanctuaries.

3. Leprosy studies are a boon to science, as syphilis was, because they involve genetics (DNA, family, geographic effects, etc.), immunology and allergy (amyloidosis, reticulo endothelial system, immune reaction, collagen vascular reaction), ethnology, climate, geography (Japanese patients in Japan and Korea get alopecia but not Japanese patients in Hong Kong, Hawaii or San Francisco).

THE THERAPEUTIC COMMUNITY: A VISIT TO HENDERSON HOSPITAL

By M.D. Parrish

A Treatment For Behavior Disorders?

This is the psychiatric unit of approximately 50 beds which Dr. Maxwell Jones started in the late 1940's. In those days practically no psychiatrists were interested in trying to treat character and behavior disorders. Such cases usually showed a lot of violent aggression, they often ended up in prison, they were completely untrustworthy and they seemed to have no guilt nor conscience. To Maxwell Jones, however, the character disorder was a challenge. He found a castle-like hospital in Surrey about an hour south of London by train. There in a great old wing of the hospital he established his psychiatric unit which eventually became autonomous and was named Henderson Hospital. It has wide lawns and pretty gardens typical of England and it crouches on a hill above a little river. I had heard about this hospital in my text books as the first psychiatric unit to successfully treat character disorders. At a medical meeting in 1963 I listened to Maxwell Jones talk about his concept of the therapeutic community. After his speech, I went up to him and asked to visit his community. He, himself, at that time was working in Scotland but he still kept an eye on Henderson Hospital. He told me to write to the medical director at Henderson and say that I had talked to Maxwell Jones and would like to visit. Well, I went back to my own hospital, which at that time was in Frankfurt-on-the-Main. When I talked to my own staff about the therapeutic community at Henderson, several of them wanted to visit. Accordingly, I wrote to the medical director and asked permission for one psychiatrist and one psychiatric aide to visit for a few days. I arranged to have them go without its costing them leave time, but they had to pay their own expenses. After they returned and made their spectacular reports to the rest of the staff, I wrote the director a note of appreciation and arranged for another pair to visit. Later I decided to go myself for a week.

Staffing

The medical director was a small psychiatrist in his thirties who wore a leather jacket and a beard like Jeff in the funny papers. He always spoke with a soft, quiet voice. The matron was a strong, attractive young woman with a good sense of humor. There was another psychiatrist visiting for about a year in a type of residency training status in order to get experience with this therapeutic community. The nursing staff was a virtual United Nations ranging from a Nigerian man to a Finnish woman. The staff to patient ratio was about the same as in ordinary psychiatric units.

Daily Routine

The day's first community event after the cafeteria style breakfast was the "community meeting". The entire patient population met in a small room with day-time staff which scattered among them. The seventy or so people were squeezed into three or four concentric circles of chairs. The chairman of the patients presided over the meeting. There was also a vice-chairman and a lady vice-chairman to help him. In that room there were about fifty patients--half men and half women--and fifteen or twenty staff members including the secretary, the gardener, etc. The patients ranged from about 20 to 45 years of age; most of them were in their twenties. About half of them had come to Henderson because some judge had said they must either go to Henderson or to jail. Most of the others were there in order to avoid losing a wife or husband.

First the community meeting heard a report from each of the established work or

therapy groups which had met the day before. Then, it heard from each of the impromptu emergency groups which usually had been called because some patient became upset or behaved in a way that others could not tolerate. For instance, one male patient had tried to rape another male in the ward about 1:00 AM. The patients on that ward immediately called a meeting of the whole ward and discussed the problem. Mainly, they said "Don't you dare try to rape anybody again at 1:00 o'clock in the morning and get us all out of bed. Next time, if you try it at noon, we'll handle that too, but this is intolerable".

After the groups had made their reports, the community considered whether any member was now ready for discharge, for special privileges or for special punishments. The patients made all these decisions; the staff only saw to it that the patients were aware of legal responsibilities. The staff did not "make interpretations". They joined into the discussions essentially as ordinary citizens, just as the patients did. Anyone--patient or staff--was respected for special knowledge or talents he had, but the group allowed no one to put down another as if he were a master and the other a servant.

The first psychiatrist visiting from our hospital had described these community meetings as places where people got up and rubbed their guts together in the middle of the group--far too stressful for the average mental health professional.

During one of the community meetings I attended, two men rolled under a bench and began a homosexual scene. Two other patients pulled them out by their collars and set them on the bench while the rest of the group went on with the meeting.

When the community meeting ended, we broke up into four work groups. These groups worked at four projects:

1. The carpentry group repaired all the damage wreaked by the patients the day or two before. This group also repaired the slight damage wrought by weather and time.

2. The tailoring group manufactured or repaired curtains, table cloths, overalls, mattress covers, etc.

3. The grounds maintenance group helped the gardener with damage to the grounds and with the upkeep of the gardens.

4. The research group collated the medical charts and compiled statistics for evaluation of the Henderson Hospital Program.

I was assigned to the tailoring group and I think it was in this group that I became really accepted as a member among the patients. They seemed to make a respectful discovery that I could run an industrial sewing machine with some skill. They simply used that discovery to accept me with. I had to have some quality more personally respectable than my medical degree or Lt. Colonel's rank. After this, we had lunch, cafeteria style. The three main meals of the day were prepared by hired cooks. The patients worked with them and did much of the cleaning. The 4:00 o'clock tea with sandwiches; however, was served entirely by a group of male homosexual patients. After lunch we had formal therapy groups. These were named for the staff person who convened the group, thus there was Betty's group, George's group, etc. But, these groups had developed to such maturity, that it was difficult to tell who the staff members were. Any patient, at any time, might be acting as a leader. I was assigned to one of the groups, and after a couple of sessions, I was accepted about the same as any patient or staff member.

The Therapeutic Community: A Visit To Henderson Hospital

There were also certain times set aside for relaxation, study, games or just visiting the little town of Sutton.

Ad Hoc Group Therapy

The emergency group meetings, called informally by any member who felt he needed it, would usually be composed of simply those patients and staff members who were nearby at the time the member got upset. The trouble was that most patients would "smash up" in order to call attention to themselves and convene a group. The patient would smash a cup against the wall and immediately a group would form right there.

Once I joined a group centered around a weeping girl who was having trouble about the custody of her child. I marveled at how smoothly the staff member handled the group and how practically and usefully the group approached the problem. This staff member was a forty year old woman whom I assumed to be a very skilled social worker. It turned out that she was simply a patient with three months time at Henderson.

An In-Take Conference

One afternoon four candidates for admissions were scheduled for a staff interview. The staff consisted of the medical director, the matron, the psychologist, the secretary, the Australian psychiatric resident, four patients who had been at Henderson three months or more--this included the chairman of the patients. I, myself, was welcomed as a visiting psychiatrist who had been accepted by the patients. We all sat in a circle around the walls of a fairly large room. The group decided to interview all of the candidates at once. They were all brought in, each accompanied by someone else from the outside world. Here were the candidates:

1. A young man who was going to prison for armed robbery unless he could get into Henderson Hospital. He was accompanied by a police officer.

2. A drug addict accompanied by his parole officer.

3. A 40 year old man whose marriage was about to break up because of his irresponsibility and alcoholism. He was accompanied by his wife.

4. A young woman who had been living a vagabond life hitching rides with truck drivers and extorting money from them. She was accompanied by a social worker.

The charts of these candidates were passed around among the doctors only. The doctors asked occasional questions pertinent to entries in the charts. The candidates, of course, had agreed ahead of time to this non-private sort of intake. The evaluation was largely conducted by the patient chairman. He did most of the talking, but acquiesed to the medical director or other staff at appropriate times. As the interviewing proceeded the candidates themselves seemed to pick up some skills in interviewing. When it was the drug addict's turn to be interviewed, none of the staff really was used to the type of drug-world language this candidate used nor to the effects of some of the strange drug combinations that he had been using. The sentenced prisoner; however, was quite cognizant of these things and soon began to interview the drug addict in the style of the staff and patient committee. Thus, the group drew a lot more information from the drug addict than otherwise it could have. This ability of the group to get unsophisticated candidates to fall into a useful manner of interviewing was the most remarkable, most unusual and most improbable phenonemon I observed in the week I spent at Henderson.

One candidate became angry at the interviewing and complained that it was very im-

portant for him to get into Henderson Hospital so that he would not go to prison. He did not want a patient committee to be making a judgement as to his admission. He wanted that judgement to be made only by expert physicians. The medical director answered in effect, "Would you prefer that they make this judgement now or next week when they kill you"?

At another moment the medical director noted that the young woman candidate's chart indicated she had been sexually promiscuous. He asked her if she thought she would be able to avoid pregnancy while she was a patient or would she prefer to be on contraceptive pills? After some thought she said she wanted to be on pills. Now-a-days, of course, it is in some places becoming illegal to deny a young woman contraceptive help but in those days almost no institution was that realistic.

It was explained to the candidates that if they absconded or if the therapeutic community kicked them out, they would simply go back to prison, to the divorce courts or whatever was their problem. Furthermore, they would receive no medications for relief of pain or anxiety. They could thus receive dilantin, insulin, contraceptives, etc., but they could not receive sleeping pills, aspirin, tranquilizers, codeine, belladonna, etc. Furthermore, there would be no private interviews with staff. Staff would see patients in groups or would see them in the hallways, but they would never sit down with a patient privately in an office. Each patient received a few shillings a week as an allowance. There were of course no locks on the doors.

Henderson Hospital

The hospital was part of the National Health Service. Consequently, it did not charge patients for service. It was apparently quite effective--at least by comparison with any other psychiatric approach to "sociopaths". More formal descriptions and outcome studies are brought out in the writings of Maxwell Jones and his colleagues.

My week of living at Henderson Hospital seems now, in my memory, like a six month assignment--so fraught it was with adventurous and stressful learning and such differences from traditional psychiatric hospitals.

#18

March 1965

GROUP THERAPY OF AN ENTIRE CLOSED WARD

by Lt. Col. Matthew D. Parrish*

This paper is a preliminary report recounting some of the effects on ward management of instituting group therapy on the ward.

In August, 1964 the NP Staff of the U. S. Army General Hospital, Frankfort, decided that continuous group therapy involving all patients and all the ward staff would provide a better therapeutic atmosphere for the new patient. Such a patient should be evaluated faster and treatment should progress further in equal time. All of the doctors and about one-fourth of the nurses and corpsmen had had prior experience in group therapy. Some were already participating in the four out-patient groups--each group with two therapists. It was generally felt that the treatment effort should be directed at the entire ward population of about 15 closed ward patients and not at its individual members. Thus the ward itself would be considered as the patient.

During the next four months however, the staff as a whole continued to talk about ward group therapy but did not initiate it. The staff found many arguments against beginning group therapy immediately. It would complain of lack of time in spite of their calculations that the group therapy would save time. Another argument was: "Since the average patient only remains with us about 8 days, he is not here long enough to derive significant benefit from the treatment. It is better to evacuate him or else to make him a long-term patient in an out-patient group." Yet, at other times, the staff had maintained that it was best to try to improve the group over the months and not merely the individual member over a few days. Thus, if the same individual were readmitted a month later he would find the group had advanced and could carry him farther and faster on the second admission. In December, the management concluded that the staff would make no serious commitment to in-patient group therapy unless the group met 365 days a year. It also seemed that the prestige of such group therapy would be improved if the chief of the service cornered it as his own project and asked only enlisted men to help him.

Accordingly, on 31 December, the chief of the service began group therapy of the entire closed ward--patients and corpsmen, 7 days a week. He continued thus as the only doctor for 32 days. Then other psychiatrists began to work intermittently as co-therapists. After 6 weeks, the chief began to come only half of the time and the ward officer became the nominal group leader. Nurses were encouraged to come, and after 2 months, two nurses were coming to about half of the meetings. Younger nurses attended better than the older ones. On Sundays there were always one or two psychiatrists in the group. Always on some one weekday the nurses and corpsmen handled the group alone in order to develop more confidence among the ancillary staff. Following the one-hour group sessions, a 20-minute "Analysis Seminar" was held by the staff members of the group. After 13 weeks, two patients were regularly asked to attend at least part of the "Analysis Seminar." These patients usually developed more feeling of group responsibility.

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Effects on Patients:

(1) After only two group sessions the closed ward patients began to interact with each other much more during the day. For instance, they would plan their work as teams in occupational therapy or on ward work details. They would also hold "kangaroo courts" and would occasionally "sentence" a member to the open ward. The staff almost always complied with such group desires.

(2) The group session allowed face-to-face encounters among patients and among patient-staff combinations to become more prolonged and more intense emotionally without loss of behavioral control. Thus the amount of daily personal interaction on the ward increased greatly.

(3) During the first month five open ward patients asked to be put back on the closed ward in order to participate in group therapy.

(4) Sunday became one of the important days of the week with its group therapy and "Seminar" following it. Sunday had formerly been a dull day for both patients and nursing staff, since many hospital activities closed down.

(5) By calling in other patients and duty personnel as visitors to the group sessions, the group concerned itself more with how to adjust to outside society.

Effects on Staff:

(1) Doctors who were treating individual patients would frequently sit in with the groups and observe the group behavior of their patients, getting impressions from an entirely different angle than was obtainable in the office interviews. The nominal group therapist did not have any in-patients assigned specifically to his care.

(2) Communication among staff members improved since an average of 5 staff members attended each group and the following "Seminar." Formerly each staff member was so busy with his own patient care that he was isolated from all but one or two other staff members.

(3) The skills and attitudes of each staff member were demonstrated to the other members during the group sessions so that everyone was able to develop faster. While one member opposed patients' attending "Seminars," another staff member was exceptionally good in getting patients to interact emotionally with each other, to reverse roles, to pantomime or otherwise express their feelings. Another member was good at revealing the hidden agenda of the group discussion.

(4) As staff members went on field duty, rotated their shifts or took leave, the composition of the therapist teams varied. The patient composition also varied but the group itself tended to progress as a coherent unit though it fluctuated in its degree of verbalizing, of creativity, of intellectuality, of emotionality, etc.

Summary of Group Sessions for the First 15 Days

1st Day: (13 patients) The ward personnel and patients had a day previously been told of the group meeting. The doctor, nevertheless, had to ask that the chairs be arranged, the card table be removed from the center of the room, and the radio turned down.

Two paranoid patients did over 95% of the talking. Other members seemed very content to let the paranoid patients pass the time and keep the others from getting involved.

2nd Day: (13 patients) Still 95% of the talk was by the two paranoid patients. Mostly they talked of their old experiences in the Navy, thus removing the content of talk as far as possible from the here and now.

3rd Day: (15 patients) About the same content and behavior as yesterday.

4th Day: (16 patients) The group was visited by one extra doctor and one nurse. The paranoid patients did 90% of the talking. Almost no utterance was related to the utterance of a preceding patient. Some of the members mentioned that there was now a lot more talk going on among them during the day's activities than there was before the group was instituted.

5th Day: (14 patients) 80% of the talk was by the two paranoid patients. When the doctor asked why they didn't talk about their present feelings, several members agreed that if they did, the group would come to blows.

6th Day: (16 patients) About half the patients talked. 10% of the talk was about the here and now. Some members related their utterances to those of other patients.

7th Day: (18 patients) One of the paranoid patients had been evacuated to the United States. The group spoke of its need for him to carry on as a speaker. The single woman patient had been ignored and silent since the first session, but today she talked about herself.

8th Day: (6 patients - many went to the barber) For the first time the table was taken out of the room and the radio turned off before the doctor arrived. Members began for the first time to talk of irritation with each other.

9th Day: (13 patients) The paranoid patient was still the most talkative single person but only produced about 20% of the talk. Most members pointed out the "crazy" parts of the other members' personalities but did not see their own. They talked of "kangaroo courts" they had been holding during the day.

10th Day: (14 patients) Two patient members and a corpsman took a phobic patient from the group and escorted him down the staircase he had feared so much to walk down. He left the group rather breezily but returned

all crouched up and withdrawn into himself. He responded to the group's questioning in short frightened utterances but seemed glad for its concern. After the doctor left, the group, for the first time, remained together, talking earnestly.

11th Day: (12 patients) Yesterday another "kangaroo court-martial" among the patients sentenced a member to the outside (duty) world. Ward doctors went along with the decision. When a woman member complained bitterly about her husband, a male member acted the part of the husband while she attacked him verbally. (Later in the day, two open ward patients requested return to the closed ward in order to get back into group therapy. This was refused.)

12th Day: (16 patients) Doctor was late for the first time (15 minutes) but group started on time spontaneously. A new patient slept through most of the meeting. Since the group could not get him to talk about himself, the members took turns ascribing him attributes, a problem and a role.

"(1) His name is John . . . (2) age 21 . . . (3) from Ohio
(4) He was lazy . . . (5) Homesick . . . (6) Scared . . .
(7) In an isolated unit . . . (8) began to hear voices . . .
(9) In this group he will probably not say much but will just let people push him around . . ."

(These attributes were practically all incorrect but patient had a hard time living them down. He was ever afterwards called John.)

13th Day: (13 patients) Two women members and a corpswoman let the phobic patient walk down the staircase. He returned with a relaxed air and sat by one of the women smoking and chatting.

14th Day: (18 patients) When the paranoid patient said he wanted to see the President, three or four members gave loud inappropriate laughs--especially a new manic patient. The group challenged the laugh as abnormal. The manic patient loudly carried on with pressure of speech. Doctor asked group how it could help the situation.

15th Day: (12 patients) The phobic patient collected 1 cent from the manic patient for each inappropriate laugh, but he paid 1 cent for each appropriate laugh. The group, as a whole, was judge. By the end of the session the phobic patient owed the manic patient 11 cents. The manic patient won friends but was still hyperactive. He asked members to vote him a pass to go to town. Not one member voted in his favor and he was very surprised. Some members fetched in a former member from the open ward and had him describe life out there.

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DISCUSSION

Patients entering an NP ward can be seen as symptomatic communications from various social groups--from unit to medical corps or from clique to clique. A suicidal gesture produced by Co. A, for example, may mean "Life is tough here; the higher echelons ought to do something about it." These human "communications" join with the hospital patients and staff who constitute inter-

communicating elements within the hospital. The patients then are processed, as if they were communicable data and are fed back to the outside world. When only certain channels of communication are open within the NP Service--when only certain people can talk easily with each other--the processing is fairly automatic. The ward functions predictably the same for decades. However, when any random combination of persons finds it easy to communicate with any other combination, then the ward becomes more creative. It changes sensitively with the needs of both medical and non-medical society.

The NP staff assumed that this processing of feelings by the communication webs within the society goes on all the time. Group therapy involving everyone on the ward merely made clear to everyone what each person was really up to. It provided a more thorough system of processing patients. The fact that the group seemed to cause improvement in individual patients was one of the social excuses for its existence, but this was incidental to its real value--summarized below.

SUMMARY:

Here was described the initiation of a therapy group which eventually involved all the staff and patients of an entire ward. The goals were:

(1) to enable nursing personnel to recapture and improve some of their historical rights and skills in the personal care of NP patients.

(2) to open up easy communication channels among all patients and staff, thus breaking up some cliques and "covert contracts" which stabilized the work at a certain medium level of efficiency.

(3) to provide a ward morale and atmosphere which maintained a higher level of patient responsibility and made it easier for patients to improve. The chief bibliographical influences upon this project are listed.

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#19

GROUP AS ORGANISM: LECTURE NO. 1
TO PSYCHIATRIC AIDES

Lt. Col. Matthew D. Farrish*

Let's go over some of the principles behind our treatment of the entire psychiatric ward as a single group. The first and most important principle is...

1. The therapeutic effort is directed at the group itself as an organism--not at any individual.

Most of us are trained to attend closely to individuals. This is important. We need to learn it better every day. But we must at the same time learn to act upon groups and to react to the feeling emanating from groups as wholes--as organisms unto themselves, each with a history, with purposes, with effects upon other groups and individuals. In this seminar we'll concentrate on how to interact with the group organism itself.

Some people have questioned how group therapy can be effective when the average patient is here only a few days. That question presupposes we are concentrating on individuals in our group work. The questioners did not grasp the idea that we were treating a group, not its component members. Similarly, in medicine we treat the whole patient, not the individual cells and organs of his body.

The duration of membership for the average patient in our ward is about 5 days. Whatever members are present today contribute to the growth of the group today. Whatever members are left over for tomorrow's group help the group to develop beyond today's status. New members who enter the group tomorrow, enter a more sophisticated group than they would have entered here yesterday. Individuals come and go but the group develops indefinitely. The group becomes in time more cohesive, more communicative and more able to plan and act intelligently. Today a two-day-old member feels that he really belongs already to the group, whereas a month ago a five-day-old member didn't feel he belonged that much.

The ease of communication and the feeling of belongingness among members soon extends throughout the day and not merely during the group session. How far will the group develop? Will it keep getting more and more efficient, sophisticated and healthy until it reaches Heaven? No, it won't because...

2. The group's development is limited by the stage of staff development. A psychiatric ward today can progress much further than such a group could in the 1920s. For in the 1920s psychiatric patients were set apart from the staff, almost like a different species of animal. They were kept locked up more. Few staff members worked with a group as an organism in itself. Most attention was given on a one-to-one basis or else on a mass basis as if the patients were ciphers. Many psychiatrists in those days imagined that the doctor had the most effect on the patients, though he might see no patient more than 50 minutes a day and never on Sunday. Now we think a nurse's aide, who

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spends many hours a day with the patient, has a stronger effect on behavior and thought. But the other patients, who spend about 24 hours a day, have even stronger effect. All of these realizations help ward groups to progress further today than they could have years ago. Will the staff's hospital experience now raise it up to work out miracles with the group? No, it won't because...

3. The staff's development is limited by the state of American culture. If our times really could not tolerate hospital staffs who dress the same as patients, who include patients in their conferences or who unlock all the wards, then the staff itself would be unable even to think of doing these things, no matter how strongly science or logic may point to them. But the ward practices we have developed here, can we not set them up in any other American community? Well, we might not be able to because...

4. The staff's influence in the hospital is limited by the state of sophistication of the community where the patients live. If a patient group develops a sophistication far beyond that which can be tolerated by the society outside, then new patients entering the group will not be able to play useful group roles and may find it difficult ever to catch up with the group. Old patients leaving the group will find they have reached an ability to interact with other people which can't be understood in the local community. Thus there is always something contrived and artificial about hospital groups no matter how sincere and open they may seem to us in the ward. Unless a therapy group remains well grounded in an understanding of local community life, it will act like an ungrounded circuit in your radio set. It may develop very high potential in its own circuit, but when it finally touches the outside ground, big sparks burst out. This is why it is so important to have revisits from graduates of the group and to have relatives and community officials come for a week's tour as group members. These visits keep the staff from thinking the hospital is more important than the community it serves.

THE GROUP INTERACTION

What can the staff do to nurture the group as an organism...?

1. The aide can arrange the seating so that interaction as a total group becomes easy and one-to-one conversations difficult.

   a. The chairs can be crowded into a close circle with no one sitting off in a corner. Tolerance must be given, however, to seclusive or otherwise disturbed patients who may temporarily need to sit back or wander off.

   b. The aide leading the group can break up cliques of patients who converse in small groups. When he moves one or two of the most active members across the circle from each other, the conversation will have to occur across the group and thus involve everybody.

2. The aide can encourage the group to keep its thought upon personal relations in the here and now--upon you and me and us, upon this group at this time in these chairs. He can encourage expression of present feelings of anger, fear, love, jealousy, sadness or irritation of one member toward

another or toward a clique or a staff member. Now every group of sick or well members fears at first that the expression of such feelings will result in blows, kisses, screams or vomitings. But when the group expresses irritation first, works up to anger with practice and gets the feeling of clear self-expression without physical violence, it fears much less its own problems. The group thus skips beyond such talk as how Alcoholics Anonymous works, how much better everything was back home, how to handle an overbearing supervisor. It goes directly on to express such things as how John feels in need of attention right here. Mary, by her attitude, then may mother him, and the group will understand within itself the type of attention it needs in part. The group may show admiration for a member's present thought or action. It may plan a picnic or an occupational therapy project, releasing in the process feelings about each member and the roles he plays in the group.

3. When the aide leads members to talk to the group as a whole and not to involve themselves in two or three small cliques with separate conversations, then the group works as a single system and builds up piece by piece the structure of its feelings and thoughts. It improves its total influence on all members. The group thus affects every member and makes him assume a responsible role for the whole group and not merely set up a debating society of two or three. When 15 people are interacting as a whole, they recall best and build up best their saner and healthier thoughts and feelings. When only two or three talk together, the thinking can be more "way out" and irresponsible.

4. In our ward groups, of course, one aide takes a week's tour at writing down in a bound notebook the general verbal content the group discusses. Another aide records permanently the general behavior of the group--the changes in seating arrangement, the activity around the coffee pot, the changes in the emotional atmosphere. Now, at the end of the daily session when these aides write their summary paragraphs, they report the action of the total group--not of individuals within the group, except as they may be expressing group feelings. The paragraph might say, for instance, that the group today was depressed, that very little talk came out of the group and what did emerge seemed sad in its expression, that talk centered around the departure of some members, or around the death of a public figure. Another time the paragraph might describe the group as searching for excitement: they sent a messenger out to another ward to bring in a fast-talking patient. He performed for them by joking with first one member, then another.

5. One of the main purposes of group therapy is to get the patients to switch to different roles. One woman, for example, may become a sort of nurse to another. One man may assume the role of master of ceremonies, another that of inciter or "bugger" of others. Another may assume the role of planner when the group wants to have a picnic. Now, the inciter, for instance, will gain experience and confidence if he shifts his role sometimes to that of planner.

6. Two patients (by rotation) are invited to the "post mortem" at the end of each group session in order to increase responsible participation of the patients, provide more patient influence on the staff's thinking and decrease the "paranoid" gap between patients and staff.

OPTIMUM GROUP SIZE

For face-to-face interaction where members respond to each other in a single conversation without a leader, the optimum size is about six members. A dinner party as large as six can still carry on a single conversation at the table. Six people, however, cannot play many separate roles, and it is difficult to switch roles among members.

From the role-playing point of view an optimum group size is about 15. Such a group can assign several roles for individuals to play, one at a time. And all roles can be present at once. It is easier too, for one member to switch out of a role because he usually has an understudy ready to pop into his old place if needed. A small group has no extra persons to serve as understudies.

Another optimum group size is the total ward community with anywhere between 50 and 100 members. Regardless of its exact size, the ward necessarily structures itself as a group because its members live together. Of course, such a large group cannot in one session get every member to talk. It also tends to produce poorly connected thoughts for the first five or ten sessions. One member's utterance or gesture will not be clearly related to that of the last member. Ideas and acts build up only slowly into any useful sequence. Nevertheless, this total community group is extremely important, for here in this group can be aired everything which disturbs the community. Later on, small groups can work over the feelings which were aired and can use these in their own planning and understanding. Often the large group is hardly more than a telephone switchboard through which many messages pass, but no particular solutions are worked out there. At other times a great deal is worked out because the 10 or 15 people who interchange group roles do it before an audience which participates emotionally in those changes. In their hearts the silent members live through those roles--back them up or criticize them by unspoken influences. These members change as the group changes. Similarly, if a hurricane blows away 10% of a town, the disaster comes to belong to the entire group of inhabitants. Your house and family may be untouched. But you still participate psychologically in the disaster. In much the same way as persons whose homes were struck, you change your feelings and your behavior toward your neighbors, policemen, firemen, the Red Cross, the politicians and the towns outside the disaster.

SUMMARY

1. Treatment effort is directed at the entire group as an organism--not at individuals. The main idea is to help the group improve and grow.

2. Patients themselves have a strong therapeutic effect on each other, for help or harm.

3. A group of a dozen or so patients tends to think more sanely than its individual members do.

4. Therapy moves faster when the group is brought physically close together and led to express feelings about present people and behavior.

5. The group improves when its members practice changing from one role to another within the group.

6. The temporary membership of various community citizens helps the group and its staff to stay in practical contact with the community life and customs the patients must return to.

ROLES IN GROUP: LECTURE NO. 2
TO PSYCHIATRIC AIDES

Lt. Col. Matthew D. Parrish*

Certain standard roles have grown up in our American mythology. We find them in novels, movies and dreams as well as in children's spontaneous play groups. What are these roles? Well, there is the hero, the villain, the supporting girl friend, the child who needs nursing, the old timer, the inciter, the scapegoat, the idiot, the clown, the coat-holder, the workhorse, the chronic challenger, the teacher, the loafer. These roles do not always have clear boundaries. They overlap a lot. We can't set an exact number. Most movies and plays only make use of a stereotyped selection of roles. A great novel like War and Peace employs many more roles and develops them much further.

The main roles of our mythology are well known to everyone and we expect to find them in the play. Children at TV will ask, "Is he the baddie?" For there must be a "Baddie." Now where do we first learn about these roles? It appears that the baby finds all these cultural roles embodied in one person--Mother. Through the mother the baby learns the significance of all the roles. For mother is herself, in part, a goodie, a baddie, a scapegoat, an idiot, a workhorse, and often she is even a child who needs nursing.

But the child's experience with mother is not social life. It is a one-to-one relationship. All the roles are played out by the two members of this relationship--although some of the roles are assumed to be not in the mother or child but in the world outside. "Hush! The Bogeyman will get you." The child nevertheless senses that the Bogeyman is part of the mother and also part of himself. He feels it within himself, and he usually doesn't like it.

In older life, say around 10 years of age, all the roles of the culture are still embodied in every member. But a particular member plays only one role at a time. He may assume one role at home, another on a playing field, and another at church. Sometimes a member plays one role exaggeratedly and exclusively. He may see himself as a no-good villain guilty for all the sins of the world, or he may see himself as a saint or perhaps as a scapegoat who is picked on in a prejudiced manner for other people's problems. A person who devotes himself too strongly to such a role will not be able to function in society and will usually end up in jail or hospital. Many of our patients have simply become enslaved to a single, narrow role.

In order to function in society, then, a member must develop the ability to experience within himself several roles, if not to act them outwardly. An important function of a dream or novel in social education is to help the individual to savor emotional situations and roles--to become more familiar with them and to manage these roles in himself and himself in them. Novels, plays, dances, games and fights are shared more with society than dreams are. But even a man's dreams are influenced by his society and the spirit of his times. They are much more like his brother's dream than they are like a Bolivian Indian's dream.

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Now if a person can reverse roles with someone else, he gets practice in developing himself. He broadens himself also if he can play for a while his own second or third best role, or if he can see someone else playing that role and can identify himself with that person as the play goes on. He thus sees himself in a social mirror.

The member, practicing these things in a group, absorbs into himself more of society, more of a mind. For his mind is a thing he has taken into himself from the outside social world--from the roles, feelings and skills that he has found in other people. He has further developed them for himself within himself.

It's all very well for a member to know that the roles exist and that practice in all of them will improve his social life and his thinking ability. But what is to keep a member from abandoning the group as soon as he's asked to take on a new and presently uncomfortable role? Suppose he is homesick and the group insists that he must stay here and work with the group. Isn't this frightening? After all, he may have been training himself in dreams, conversations and stories to avoid committing himself to such a role. Will he not then withdraw into a corner and sulk? --Or perhaps desert the group? No, he usually doesn't because the group will not challenge his beloved personal role and make him play another until he has become a glued-in member of the group and the group has become a member of him--a part of his thinking and feeling. Before any changes can be impressed upon the individual then, a feeling of group belongingness and mutual support must develop in all the members.

Let's talk about group belongingness for a minute. We hear that self-preservation is the strongest instinct. Why, then, do men charge to certain death in battle? Or why do some people sacrifice themselves to save or improve the life of a family member? Well, if self-preservation is the strongest instinct, then a member must consider himself and his group as somehow the same thing. His mind and his feelings do not necessarily exist only inside his own skin. His habits and customs, and indeed the very grammar with which he thinks, came to him from his group. Originally his family gave him his language, customs and ways of thinking, and then his buddies, entertainers, and teachers added more. Most people have belonged closely to very few groups in their lives, and they eventually find it a very satisfying thing to belong. Once a man is glued-in with a group, then the group can challenge some precious behavior of his, and he will have to change or else lose membership which is now even more precious than the behavior.

Look at it this way: A group when it changes a member is adjusting a part of its self. A member when he changes his behavior is making a self become congruent with a certain group. In another of his groups he might behave differently. An individual is the combined echoes of all the groups he is a member of--in memory and in the present. But the present group can always become the strongest influence.

How can a group be helped to develop a feeling of cohesiveness so that each member truly belongs? Well, each member must openly exercise his inner feelings and his personal abilities at a time when these feelings and abilities fit into the needs of the group.

This revelation of individual self and this fit to the group are promoted when the group is sitting closely together and no one is providing any preoccupying distractions. Members become embarrassed by their own closeness to each other and by the silence. Some member may then show an ability to break this embarrassing silence. But in so doing, he reveals something about himself. He may, for instance, show that he likes to make a bid for leadership. A couple of other members may then throw him down from his leadership position, but he will show the group, perhaps, how he is hurt and discouraged. Other members will feel they have a lot in common with this type of ambition and of hurt. Someone may begin to play nurse to him and thus reveal something about his own character. Gradually all members begin to feel that they are very much like all other members. Then they feel that even their unique differences dovetail to advantage in the group. In this group they live fuller and more expressive lives, develop more expressive selves. They find they can express feelings here they could not express elsewhere.

When a member of a ward group becomes skillful in playing all the roles natural to that group, he puts himself together on a higher level of mental health and individual comfort. Eventually a member's feeling of self-confidence and self-worth within the group--the ability to accept even the more distasteful of his thoughts and personal characteristics--can be transferred to a similar confidence in his membership in other groups. From a ward group he may move to a work group, a family group or a playing team.

Summary

1. There are 5 or 10 major roles in a society which carry on all the thinking and acting life of the society.

2. These roles are delineated in novels, dreams and games.

3. Every child learns to feel with and to act with each of these roles through playing games, working with gangs, following stories and movies, dreaming dreams and sometimes practicing those roles in serious life.

4. An individual's effectiveness can deteriorate when, for example:

   a. He confines himself to a single role and never appreciates any other roles nor feels them as part of himself.

   b. He denies to himself all feeling for any of the major roles.

   c. He becomes frightened about an unacceptable role which he feels within himself as a disturbance, even though he doesn't practice it.

5. A group member develops a broader personality, more social skill and confidence, when he feels his way through all the major roles in turn--talking and playing with other people in such a way that he openly exercises all the roles and gets used to them within himself.

6. Individual improvement occurs fastest when stimulated in a lively group which is large enough to contain all the roles simultaneously.

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THE GROUP'S INFLUENCE UPON THE UNCONSCIOUS: LECTURE NO. 3 TO PSYCHIATRIC AIDES

Lt. Col. Matthew D. Parrish*

Insight and the Personal Unconscious

In the 1890s Freud and others examined slips of the tongue, humor, dreams and the free associations in the unhindered flow of patients' speech during long interviews. These examinations revealed that individuals were unaware of the reasons for many of their acts, thoughts and feelings. They were unaware of certain of their prejudices, beliefs and patterns of thinking. This part of thought which the individual was at the moment unaware of was called the subconscious mind, or the unconscious mind. These early psychoanalysts thought the self could be made stronger and able to make more reasonable decisions if most of the unconscious mind could come within easy awareness.

A certain man, for instance, was irritated when his boss had him type out the office's weekly reports. The man didn't dare show his irritation. He hid it even from himself. Unaware of his underlying irritation, he typed away. He made mistakes however, that cost the company a lot of money. Psychoanalysts thought these mistakes were expressions of vengeance from the unconscious mind--from the irritation the individual was not aware of. Now if, through therapy, he became aware of this irritation, he could tell his boss that work irritated him and could suggest a better way of doing it. Or he might even quit that job or get himself transferred. He could not do any of these things if he remained unaware of his irritation.

In order to bring a person's unconscious into awareness, the psychoanalyst first gave the person the status of "patient" in his society. Second, the analyst conducted a special form of one-to-one interview over a period of one to five years. Exploring together the thoughts and feelings of the patient, the analyst and patient eventually brought much of the patient's unconscious mind into the awareness of both patient and analyst. The patient became more comfortable.

Groups that Reveal an Individual's Unconscious

In the 1940s, however, Washington and Baltimore psychiatrists, influenced by Dr. Harry Stack Sullivan, discovered that a patient's peers often saw clearly things that he himself was not aware he was doing or thinking. The peers as a group could very quickly make the patient aware of these things and could change his behavior.

Let me say parenthetically that a group itself has an unconscious too. It does many things, practices many customs, without realizing it is doing them. The U. S. as a national group has an unconscious. Just as other individuals can bring out a patient's unconscious needs and behavior, so groups of nationals from Europe and the Far East can reveal some of this U. S. national unconscious to us. That's one value of our working in Germany. Theoretically, we help the U. S. to learn a little more about itself.

The following observations seemed important to men studying the behavior of groups:

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1. One observer might well be as blind as the patient to all of that patient's significant unconscious feelings and beliefs. But what one group member is blind to, another sees clearly.

2. Although analysts were well trained to understand their own ways of keeping things unconscious and could, therefore, understand many other people, they were poor at understanding people from a different social class, a different national culture, a different way of working and living.

3. The individual analyst didn't dare confront the patients too suddenly with the unconscious material. For then the patients might develop such strong feelings about the analyst they would stop further progress.

4. The analyst alone could not contain an agitated patient as well as a group could, nor could he produce pressure from all sides that a group could produce to alter immediately the patient's attitudes and behavior. In a group there would be pressure from such types of people as a motherly woman, an old man, a pretty girl, a clown, an enemy, a warm friend.

Some members of a group, for instance, might see immediately that one member was irritated at his boss. With chiding, with humor, with mimicry the group would demonstrate the patient's own irritation to him. They would support him emotionally as they built up his confidence and his good planning preparatory to his talking with the boss.

A member does not change his life's bad habits simply because others see the unconscious roots of those habits. He doesn't usually change even when he becomes aware of these once unconscious feelings. He changes after he has had practice in living through these feelings and thoughts in little dramas or perhaps in real life. The drama includes all the pertinent emotions and the body sensations that go with them. The emotions are most manifest, for example, when a second member takes his part and with suitable coaching plays out in voice and gesture what appear to be the first member's typical behavior and emotions. The coaching comes from the first member himself as well as from the rest of the group. The first member then sees himself as others see him. He is able to laugh or cry at his own behavior in the same way that others could. He may also perform his own part, repeating his characteristic words, cliches, and mannerisms of gesture and posture. He performs them in such a deliberate way that he gets a clear perception of them in his muscles and senses--not merely in his intellect.

So far I've talked of three levels of understanding or "insight" which may change the behavior of persons:

1. Intellectual insight, where the member says, "Ah, now I see that all this time I've been irritated at the boss!" But he examines this idea objectively, as if it were something apart from his personal self.

2. Emotional insight, where the member finally grits his teeth and feels the irritation against the boss and energetically thinks up plans of vengeance or ways to change his job, etc. He feels the irritation itself participates in his thinking.

3. Dramatic or action insight, where the member, coached by the group, may play out his irritation. The coaching group clearly perceives much of the original restraint and conflict. The member argues with gestures against another member who takes the part of the boss. The first member himself plays out his own angry feelings. Later he may play out his fear of the boss or his satisfaction at some parts of his life with the boss. Now he has fit his irritation into purposeful action, useful with other people.

Influence of Roles

Now, within the therapy group or within the shop or family group the member may seem to be a pure villain, a pure hysteric, or any other sort of pure character. He may become conscious of himself as that character. Such a pure character, however, exists only because the group sets itself up as needing such a character to react upon; to receive some of their love or hate, envy or praise. Because of his past training and experience, a certain member may be better able than another to fit into a particular character which the group needs.

The role, determined by the group, goes in search of a character to fill it. Some member, with certain past experience and present attitude, will fit it best. But no person fits a role perfectly, and some new character may displace him. The role may also change the person's behavior or his personal character. He may learn to fit better and to change a bit as the role changes with the style of the group's behavior. If the group changes some of the things it needs that role to do for it, the member must change or else other members who fit better will replace him.

Any role is a dependent variable. Its automatic changes depend upon the changing needs of the group. Similarly, the distance an airplane can fly depends on how much gas is in its tanks. Change the amount of gas and you change the distance the plane can fly. Change the needs and structure of a group and you change the quality of demands put upon various roles.

Though a patient fills role, he is not himself a role; he is a person. His behavior and his prejudices are determined by his position in several groups--family, company, hospital ward, the gang he hangs out with on weekends, the ball team he plays on, the class he studies with at night. At any one time he is more committed to one of these groups than to the other. Let's say he is ordinarily committed most strongly to his family. But when playing second base he is temporarily more committed to the ball team than to his family. Typically a man is most deeply committed to a group when he is presently playing a role as a member of that group.

The lifelong behavior and personality of an individual is in large measure determined by the area of intersection of many groups. It is determined, that is, by the sum of the roles that individual plays in all the groups where he is a member. His behavior at any one moment is usually consistent with only one of these roles--the role he plays in the group he presently feels himself a member of. Thus he may not play the role of truck driver very well because he is always thinking of his role as father. In order to be effective economically a person must be able to commit himself fairly well first to one group (the transportation company) and then to another group (the family).

Summary

1. The individual's unconscious mind is only unconscious to himself. A group he works with may be quickly aware of many things in that unconscious.

2. Groups set up roles. Groups can alter them. All individual members participate in the determination and maintenance of each role.

3. The various roles a person fills largely determine his behavior, his feelings, and his thought.

4. Groups can bring a member quickly to understand some of his unconscious and to change his attitude.

5. An individual may improve if he gets an intellectual understanding of some of his unconscious impediments or hangups. The intellect distances things from the self. Ideas and feelings are examined by the intellect as if they were not a part of the self--as if they were "not really me."

6. An individual improves further if he feels these impediments in their full emotional impact.

7. An individual improves still further if he can act out in a well practiced drama all these feelings--with accompanying postures, gestures, and expletives.

8. The group helps him to express himself and to plan for the future.

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HOW TO MAKE PATIENTS SICKER: LECTURE NO. 4 TO PSYCHIATRIC AIDES

Lt. Col. Matthew D. Parrish*

In our previous meetings we talked of how we treated the ward therapy group as an organism, how we brought the patients together to form a group which could progress onward as an organism and carry with it all its members, including the therapists. At the same time, we saw the group could, if it would, perceive the unconscious hangups and conflicts within an individual's character, and further could help the individual to understand himself and to change his behavior.

Now let's discover what happens if we try to make the patients worse in a group. We aren't really going to attempt this, I hope. We simply need to think about what can make patients worse in order that we can return to curative work and understand it better.

First let's consider what the average patient feels about the hospital. Remember that most patients do not enter any kind of medical treatment with the idea that they will be responsible for their cure. In medicine or surgery this "irresponsible" attitude may be desirable. A patient who is having his gallbladder removed must, after all, cooperate and become very dependent on the surgeon. Have you ever seen a patient responsibly take out his own gallbladder? After a temporary period of being taken care of like a child the surgical patient gets up and faces the real world as usual--providing he has not spent several months in the hospital so that hospital life and the attitude of dependency itself has become an added problem.

In psychiatry, on the other hand, we usually consider the patient's main problem to be a regression back to a child-like way of behaving so that he must have someone else to take care of him even though he is physically sound. To improve our patients we get them to develop their own skills and responsibilities, eventually to re-encounter the recurring problems of life. Our patients can hardly improve their skills or their feelings of responsibility by letting the doctor tell them what to do. They do this by managing themselves among ordinary people, not among doctors and nurses.

But let's see in what way the average patient becomes sicker if we allow him to become overdependent. Each individual in a treatment group will expect the leader to do something for him. He will usually want special attention for himself. He will see the other group members as rivals. The group leader who wants to cause a regression toward helpless dependency can utilize this natural expectation of every patient by talking to each one in turn as if this leader had special concern for that individual patient more than he has for the group as a whole. While the other patients passively listen, the leader talks to one patient about past difficulties. And the past is any time before this group got together for today's session. Leader and patient carefully avoid considering what is going on right now between this patient and the group, essentially ignoring the other members. The patient's overtalkativeness prevents the equitable give and take with other members--the give and take that would normally integrate him as a member.

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If the leader can keep the members committed only to the hospital and to this artificial therapeutic group, they may find it uncomfortable to go back and become integrated into the natural groups where they live, work, and play.

As a last ditch stand, then, to keep patients sick the leader must try to prevent patient visits to the companies and the natural work teams outside the hospital. He must prevent also any visits by company members to the ward or to its group sessions. A good argument to use among hospital staff members: "These undependable patients will go to their companies, join up with some other psychopaths or deviates, be led astray and get sicker... They'll have an alcoholic binge, a drug trip, or a sexual orgy." Such expectations on the part of hospital staff greatly aid the patients to behave in that expected way.

Here is a list of the rules for making the patients more childish, irresponsible and psychiatrically ill:

1. The leader of the ward group encourages the individual patient to talk to him as if he personally were going to cure the patient. He thus treats personally in the group, setting one patient after another.

2. The leader encourages the patient to talk about private things outside the immediate group. The patient will then be exposing very personal facts of his life in a public setting.

3. The leader acts as if he never had any strong feelings nor any emotional difficulties.

4. The leader, acting as if he wanted the patient to restrain feelings, helps the patient to transform any true feelings into anxiety.

5. As much anxiety as possible is passed on to the leader or perhaps to some other staff or group member.

6. The staff prevents the patients from associating privately with each other or meeting as a group in the leader's absence.

7. The staff allows no part-time hospitalization. It prevents visits to companies. It prevents discharged patients or other company members from visiting the ward or its group sessions. It keeps out the atmosphere of the natural outside world.

8. The leader tells the ward and its staff that he expects the patients to remain sick a long time.

If by following these rules a leader cannot make most of his group members sicker, then he may be justified in saying the members are abnormally healthy.

To make the patient feel less adequate and more likely to regress into dependency, the leader should pretend that he himself has no strong feelings and no emotional difficulties. Each patient, assuming this is normal in the group, will feel abnormal himself and will strengthen the wall between the competent and objective leader and the worried patient.

Have you noticed that a patient treated in these ways often talks in a detached and unfeeling way about his past troubles? The patient who talks only to the leader will sometimes find himself exposing private facts of his life in a public setting. This will stir up anger, embarrassment or even fear within the patient. In order to keep on talking he will have to tense himself and maintain an expressionless face and voice (or make frequent inappropriate laughs or jokes). Now, this tense restraint of real feeling, this holding back of anger, fear or love is anxiety.

The strange thing about anxiety is that it is easily negotiable or transferable. Like money or a check, it can be passed on to someone else. Having brought our patient away from his real feelings and to the point of anxiety, we can now let him pass his anxiety on to some other member--best is to the leader. The leader hustles around, getting excited about all this private material the patient is talking about, and begins to worry excessively how he can cure this situation. The patient can then regress blissfully. He will become irresponsible--passing any blame forward to medical authorities; in other words, he becomes a career patient. Because of his present lack of social feeling and because he feels manipulated, the patient will often see the people around him as objects to be manipulated rather than as persons each with his own set of enjoyable and distasteful peculiarities.

Now, you would think our patient could stay in the hospital for years without much change in his feelings or in his ability to take on responsibility. He might. But usually a group's tendency toward mental health is so great that it's hard for even this unnatural leadership to prevent some feeling from coming to the surface. Here's how it works:

Our patient is irritated at the leader for embarrassing him in public and also for not curing him quickly. He usually smothers this irritation well enough to continue his dependent status. The patient is also irritated at the group for listening to his secrets from the past; and this anger is far easier to express. Group members get angry at each other even though the source of their anger is largely the leader. When the group members see each other in private, however, they will easily express together their anger against the leader--tentatively at first but with increasing vehemence as they meet outside the group itself and share more of their feelings. Soon a patient will express open hostility toward the leader in the group session itself. The group will usually go along with their spokesman and will thus become in public a purposeful organization. Members who were formerly expressionless may now learn to have feelings quite openly and to stand responsible for them. In order to keep the patients sick the leader must delay this formation of group cohesion by preventing the group from meeting outside the formal group sessions.

But let's assume that in spite of all the leader's efforts the members do form a coherent, self-helping group. Nevertheless, it is still an artif cial group not productive in the world of work and learning and child-rearing.

HOW TO MAKE PATIENTS HEALTHIER: LECTURE NO. 5
TO PSYCHIATRIC AIDES

Lt. Col. Matthew D. Parrish*

Today let's see how we can prevent the patient's regression and promote his development of responsibility and skill in human relations.

When we act as therapists of the group we do not consider the group's aim is to cure any particular individual. The patient and staff have this aim only before or after the patient is a group member. In a hospital the individual does not pay primarily for a cure. He pays to join the group and to function as a member while the group goes onward with its own life development, carrying all the members along. An animal similarly carries all its useful organs along with it, thereby making each organ healthier than if he prevented his organs from all working together.

In the early 1950s some psychoanalysts reported that a psychoanalysis in Israel took only about a year to complete, while in Europe or America it took from three to five years. The European patient, after a year in Israel, would become so absorbed in the work and the challenges of the buoyant new state that he would have less need for his old troubled self, his old hangups. The Israeli life would bring him a new sense of self, a new way to absorb himself in an enthusiastic society.

A patient will absorb himself in a group if the group, not the individual, is the leader's primary interest during the group session. After such commitment the patient can more naturally absorb himself in the productive social world outside the group.

Some leaders, however, continue to develop one-to-one conversations with each patient in the group because they fear that each patient would otherwise lose his unique individuality and become a cog in the group machine. Actually, the leader who drops this fear finds that each patient extends his own feeling to include the kinds of feelings experienced in every "seat" in the group. The leader soon feels his own unique self extending its roles and its understanding--becoming warmer and more specifically personal both inside the group and out.

What characterizes the therapeutically effective group leader?--

1. The essential thing that makes him a leader is that he is not only an accepted member of the group but also an accepted member of the staff. The staff is a set of people which the outside world has licensed to lead many therapeutic groups.

2. The leader is warmly human, susceptible to feeling, and easily shows the subtle nuances of his feeling within the group.

3. The leader need not be more intelligent or more informed than the other members of the group.

4. The leader must be supervised, whenever possible, by some other member of the staff so that he can maintain a better therapeutic

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perspective in the group. Of course, it is ideal to have a co-therapist to check him.

Since the leader is only a member of a group and not supposed to be a great expert, he would be presumptuous if he began the group sessions by telling the group what to do. He need not encourage the patients even to introduce themselves to each other. Indeed, they can find such minor stereotypes as name and job in the process of working with a problem and of developing feelings with each other and with the group. (Start working first; then later you will get to know whom you are helping.)

If the patients ask the leader, "What are we supposed to do?" then the leader may show a bewildered expression and say something like:

"--You really don't know? Why, I had supposed that we were really going to get to know each other here."

"--We're eventually supposed to work together as a group to understand how to get along better," or..."to live without so many problems," or... "to feel better."

"--Gee whiz! I wonder why we all act so helpless."

The leader necessarily sits there expecting that the group can and will get on with forming itself into a cohesive, working organism, increasingly skillful in human relations, increasingly well related to the members and increasingly expressive of true emotions.

Now, such an attitude on the part of the leader will not lead the patients to suppress their feelings. It will, at first, hurry their expressions of direct hostility against the leader. It will also discourage individual patients from trying to get private treatment out of the leader in a group setting. The hostility begins to develop as soon as the group realizes that the leader is not going to do its work for it but is simply going to join in like any other member. His activity, too, will be no more than the average member's.

After living through the hostility and through the affection which follows it, the group will pass usually to a stage where individuals talk directly to the group. Obviously anything spoken aloud is said to the whole group anyway. It is foolish to pretend it is a private communication to one person. The individual speaks as himself, with his true feelings, in the here and now. As individuals begin to get practice in slipping into and out of different roles within the group, then each individual will speak to the group with a personal self that has been developed, in part, out of the group and composed of some of the feelings of every group member and every group role. He becomes confident in living with any human feeling.

In a later stage, the group may talk to itself, using all roles to talk to the reasonableness and the memory of the group as a whole. Everything an individual says, then, is stimulated by what went on before in the group, and it contributes to the further stimulation of the group. New ideas fit into other ideas and interlock to create a definite structure of thought.

Summary

I have now gone over the advantage of moving the group as a whole rather than trying to improve each private individual in the public group setting. The leader who maintains a warm empathy with the group and its members, experiencing and expressing his own emotions as they arise in the group, finds the group easier to work with. This honest feeling usually becomes an essential part of therapy and of group leadership.

MARATHON GROUP LITERATURE

PLATO: Symposium (all night with eating and interruptions) discussion of love and friendship showing how the character of the talker fits into what is talked about and into the total feelings of the group as a whole.

Phaedrus: On the expression of individual thought, how feelings and thoughts may be arranged in the mind.

J. P. SATRE: No Exit: A play about three people in Hell. They are just staying in a living room together forever. They talk too much about the past, however, for it to have the verbal content of our kind of marathon. Still, much of the here and now is affecting them.

LUIGI PIRANDELLO: Six Characters in Search of an Author, Henry IV, It Is So If You Think So

Where does play end and reality begin; what is audience and what is actors?

SAMUEL BECKETT: Waiting for Godot, End Game Some people's basic assumptions. They act as if they didn't know things that they really do know.

IONESCO: Rhincceros, The Bald Soprana What is reality in the face of the need people have to play games?

WILLIAM FAULKNER: Sanctuary and perhaps Light in August, and As I Lay Dying

Emotional time against clock time. Discontinuities of events & thought.

ALAIN ROBBE-GRILLET: The Voyeur, La Maison de Rendez-vous. Similar to Faulkner but a step beyond him in craziness and modernity.

WILLIAM GOLDING: Lord of the Flies Unexpected feelings underlie the behavior of an individual or group. An isolated group, intensely interacting, develops its own laws, religion, customs --Sometimes customs incompatible with those of the mother society.

C. V. GHEORGHIU: The 25th Hour. The character a man must become when forced to it by a group. The switching of loyalties which had once defined the self. Complete commitment to first one thing then to an incompatible other thing.

J. GIRAUDOUX: Tiger at the Gates (In French the title means "The Trojan War will not take place") Helen as a beauty queen. Men as a group end up doing what no one wants to do?

GOETHE: Faust Part II Especially Act 3. Broad intellect experiencing many historical and personal acts. Helen as a beauty queen? Idealism and authority. The bad and the good in the same soul.

THE PROBLEM OF BEING FROM IOWA

Lt. Colonel Matthew D. Parrish, MC*
Lt. Colonel Ralph W. Morgan, MSC**

THE PATIENT-ORGANISM considered in this case is that of a military unit. As with individual patients, an organ or a symptom is presented as *the* problem and often the patient doesn't want his "whole person" treated. It is only occasionally effective to treat a single symptomatic organ in a person or a single symptomatic individual in a unit. Every individual psychiatric case referred to the NP Service is therefore logged in as a member of a unit; then at least the unit's rate of psychiatric complaint is considered. That which is seen in the group as a rate is seen in the individual as a probability or in other words, as a prognosis. A small group like a company, however, can behave as a single organism with own prognoses.

Background

During the Psychiatric Service's routine visit to a dispensary, the dispensary surgeon supporting the nth QM Company reported that sick call rates were double that of comparable companies. In the past four months there had been one suicide and three divorces. The surgeon felt that unit consultation would help and told the C.O. that he wanted to call in a command consultant for one afternoon. The consultant was a psychiatrist assisted by an E-5 Social Work Specialist.

The QM Company, in its chronic, somewhat understrength state, consisted of a Captain, three Lieutenants and 155 EM. The officers and especially the commander talked at length with the psychiatrist while the NCOs and some privates talked to the Specialist. The commander was from Iowa, age 32, unmarried and showed prodigious energy and extreme meticulousness about details. He had had long service as an EM and considered himself a member of the old "brown shoe" army. The army and his unit's mission was the central focus of his life, and his Lieutenants felt he was always way ahead of them. He maintained a very detailed card file on every member of his unit and often worked until 2200 hours keeping up these records, interviewing complainers, etc. He felt he had been placed in command by this headquarters in order to "straighten out the unit. He laid out, for the psychiatrist, the difficulties as he saw them:

(1) The membership of the company was too largely "poor material." Many of his men had medical profile restrictions and were assigned to the Quartermaster because it was felt that Combat Arms would be too demanding upon them.

(2) The NCOs took less than average initiative and responsibility.

(3) The Lieutenants were inexperienced and not to be trusted far.

The commander had tried to meet the growing problem of his unit by increasing suppressive measures. When the sick call rate rose, he required each man to check in all his equipment before going to the dispensary. On return from sick call, members had to redraw their equipment. The troops were marched to and from sick call by an NCO, specially detailed by roster. This and similar measures of close supervision had required longer work hours for NCOs.

The troops had met the CO's effort with increasing passive resistance. The most flagrant example was a recent one which the commander dwelt at length:

A tank truck driver in the unit had brought a load of 5000 gallons of gasoline to a storage depot. When a civilian employee had pointed out the storage tank to him, the driver knew from the color of the intake pipe that this tank contained Diesel fuel. He did ask the civilian employee once more if he were sure that this was the correct tank. On being cursorily reassured, the driver put the whole 5000 gallons into the tank of Diesel fuel, thus rendering useless both gasoline and Diesel fuel. In the subsequent investigation which was still going on, it seemed that the commander would be held financially liable for this "mistake."

Group Data Gathering

In order to gain further data, the command consultant and his enlisted assistant obtained permission from the C.O. to talk with members of the company individually and in groups. The group interviews with the troops allowed one member to stimulate another so that a kind of "group memory" was tapped regarding group behavior. Thus many of the ramifications of the unit's attempts to manage the C.O. were brought to light. Although there were several examples of bright NCOs who had special profiles for orthopedic difficulties or allergies, the general intelligence level of the lower grades seemed somewhat below that of the average Infantry company. Most significant, however, was the manifestation of a facile but covert cooperativeness among the troops, which no one member was fully aware of. In general, the troops were developing a cache of tradition concerning their struggles with the commander. It appeared that the commander himself had interpreted this response as meaning that the unit had been assigned "poor material." After one incident which had particularly irritated the commander, he addressed his men to the following effect: "I know that I am having trouble with you men, but I will tell you one thing. In all my long experience I have never had trouble with a man from Iowa." Within the week, another incident occurred. The picture of the commander was removed from the "Chain of Command Gallery" and defiled in a particularly disrespectful way. The culprit, a member of the company, was found with surprising ease. He turned out to be a bright and willing worker who had always been cooperative and never in trouble, but surprisingly he hailed from the state of Iowa.

In group interview with the consultant, the troops brought out that right after the commander had made his pronouncement about men from Iowa, they had quickly pooled and searched the company-memory in a manner which seemed reminiscent of a digital computer with human parts. There was only one man from Iowa, and regardless of his former desires to remain meekly in the background, he was the only Pawn in position to check the King. He had to like his role, because all of his social world liked him in

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it. Several members made him happily drunk and inspired him to desecrate the commander's picture.

Command Consultation

In the consultant's interviews with the commander, no advice was given, but rather, the commander was led to review in his mind and to explore the possible meanings of all that had happened. The commander then concluded:

(1) That he was trying to do all the work in the unit himself and was failing at this impossible job.

(2) His officers and enlisted men were probably no different from those which any other Quartermaster unit was getting.

(3) That when the commander defined a group as an incapable one, it usually responded as if really were.

(4) The troops were showing, indeed, a good deal of energy and ingenuity in working with what they considered their real problem!

(5) The mission could not be accomplished well unless the commander could induce in his men the motivation to use most of their collective ingenuity aggressively toward the formal mission and not toward the hidden mission of obstructionism.

In the presence of the consultant the commander laid out the following plan:

(1) He would reduce all non-essential duties which took up the time of the personnel, e.g., NCOs would stop marching men to sick call.

(2) He would encourage and secure continual suggestions from his officers and NCOs on how the mission of the unit could be better accomplished and would allow them, as far as possible, to work through these suggestions, with responsibility of their own.

(3) He would place the responsibility for already defined sections of the unit mission upon his officers and NCOs and allow them to carry out these responsibilities in their own ways - failing, if necessary, on their own faces.

In the ensuing weeks the dispensary physician reported that the sick call rate had fallen below the average. Occasional members seen by workers of the psychiatric section reported changes for the better to the point that no further formal contact was considered necessary by the consultant and the unit's health was merely followed through the surgeon.

DISCUSSION

Much the same consultation attitude and techniques employed in this case are described in extensive civilian[1,7] and military[3,4,5] literature. There is no particular diagnosis in this case; the initial problem is to isolate the disturbed social organism.

The treatment of the community organism as a whole (so-called Third Psychiatric Revolution) has its concurrent "revolutions" in Industry and Management.[6] This concurrence has increased the usefulness of human relations consultants to command managers. In this work the medical profession has great advantage in that society does not question the prerogative of the doctor to communicate intimately with all echelons. In most military cases, the consultant simply enters the unit along the lines of communication and the good will already established by the battalion surgeon.

While most managers will agree that other people's units be looked at as a whole, they tend to see errors in their own units as due to the acts of some particular individual, and they may try to induce the doctor to treat certain individuals and carefully to neglect the rest of the group organism. Because the military commander is responsible for the mental health of his unit and its individual members it is relatively easy for the surgeon to involve the commander and the unit as a whole. This is done routinely in Preventive Medicine; and psychiatry which examines many "stylish" symptoms and "faddish" behavior so much influenced by the prevailing social outlook, is often a form of Preventive Medicine.

SUMMARY

A case is described in which the behavior and symptoms of certain individuals were seen as communications symptomatic of a disturbance of the total unit as an organism.

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MYELOFIBROSIS: A Brief Review

Captain George S. Groch, MC*

THE TERM "MYELOPROLIFERATIVE DISORDER" encompasses a group of rather diverse clinical conditions which are characterized by the disorderly proliferation of hematopoietic elements. The most commonly recognized forms are polycythemia vera, myeloid leukemia, essential thrombocythemia, and myelofibrosis with myeloid metaplasia.

The confusion surrounding this entity results from the innumerable, intermediate and overlapping forms of this disorder and the myriad of titles under which they have been reported such as "agnogenic myeloid metaplasia," "myelosclerosis," "osteosclerotic anemia" "chronic nonleukemic myelosis," etc. The common

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THE LONE INNOVATOR

Extract from a letter to Matt Parrish, 27 April 1966, from Dr. Thomas F. Main, Castle Hospital, Ham Common, Richmond, Surrey

...I have several times seen one doctor in a whole hospital attempt to run his ward as a "therapeutic community" in a pioneer-like way, in a hospital from which he has not first got social or scientific sanction for his efforts. The result is, and can only be, that his work then becomes anti-social; virtuous, progressive, noble, with all evil and all stupidity gone, and located now in his seniors and colleagues. This noble fellow and his noble staff, so progressive and sincere, then get the belief that the failures of their unit are due only to ill will and stupidity of the out-group. This situation prevents such a doctor from noticing or examining this total projection system. You see the idea—a high morale paranoid team ensues, which becomes increasingly irritating to the administration.

I mention this because I believe that before any innovation, essential sociometry needs to be done at the highest level of the hospital administration. A ward experiment can only proceed on a basis which the rest of the hospital can accept, and regular discussions with the rest of the hospital are essential if its sanction is to be obtained and maintained. To put it in another way, it is unfair and unwise to pretend that the rest of the world does not exist.

...At your level...your job, indeed, is not psychiatry but "the higher psychiatry"—interest in, identification of, and work with the inner staff tensions, which always arise between the experimenter who seeks change, and his colleagues.

5/7/73

KERYGMA AND MYTH--THOUGHTS AFTER READING THE BOOK

Rudolph Bultmann, New Testament and Mythology,
in Kerygma and Myth, N.Y.: Harper Torch Books, 1961

This essay was written by a German Protestant theologian during World War II. (Kerygma means "proclamation.")

The task is to de-mythologize the New Testament's proclamation. The New Testament asserts that Judgment Day will come in the lifetime of people living in Jesus' time. Mark 9, 1: "...there be some of them that stand here which shall not taste of death till they have seen the Kingdom of God come with power." 1 Thess. 4, 15: "...we which are alive and remain under the coming of the Lord shall not prevent them which are asleep." St. Paul thought that he would live to see the Kingdom of God on earth. Actually he did see it in the beginning of the Kingdom of Orthodox Christian society.

Today, modern scientific man finds it difficult to accept any myth and he thinks the New Testament is a form of myth, for it does not treat the story in a "scientific" manner. Nevertheless, a myth that lasts for centuries has a value to many different people and becomes almost a biological symptom or drive--because it crosses many cultures and it seems to have symbolic truth to man as a species. Mythology is simply one way of expressing a world view or a set of concepts. It is an especially useful way to put across a world view which is contrary to a traditional way of thinking but which many men already partly believe.

In the last few centuries we have relegated myths to the province of entertainment, and their former place as belief-changers has been taken by a succession of more "scientific" approaches to philosophical questions. For instance, St. Thomas, born into a world which took most everything on faith, convinced his contemporaries that Reason was valuable in theology. Luther showed that individual man was so valuable he needed a hot-line to God. Copernicus showed that man was not the center of the universe, Galileo that bodies follow laws of motion. Newton introduced the concept of gravity among all bodies in the universe. Darwin gave man only a certain historical place in the development of the species. Freud showed that man's actions were not entirely under his conscious control. Spengler showed that European history was only one history in a procession of histories which come and go. G. H. Mead showed that the individual's sense of self and mind were derivatives of society. Society was not a derivative of many individualisms. These concepts and world views have the same effect as myths but they are not expressed in mythological language.

The world view known as "Romanticism" is essentially a middle class view. It was a reaction against the Enlightenment, when men had revered pure reason and followed it wherever it might lead, even if it led to the destruction of man. When the French Revolution and the American Revolution put the middle class in the driver's seat, the age of Romanticism discovered that man was more interesting as a feeling individual than he was as a reasoner. Man began to be seen as an autonomous being with a mind of his own even though he did fit into history, evolution, etc. In harmony with this individual view, nationalism developed--creating a set of autonomous and commercially competing nations.

It seems somehow characteristic of man, however, that he accepts a myth or a science in his religion or in his laboratory but he denies it in everyday life. For instance, he may believe, in his laboratory, that smoking will cause him problems he doesn't want, but in everyday life he denies this and smokes like a chimney. Bultmann felt that science now determined the world view, and faith therefore degenerated to superstition. Actually our formulation of the world is simply put in a scientific framework. We are even untrue to science.

Perhaps what was proper as faith is now replaced by "knowledge" but St. Augustine, St. Thomas, and others were astute and reasonable men who fit in with large groups of reasonable men. They didn't just accept superstitious things, and pass on. The vast consensus which included these high thinkers developed faith and doctrine--not superstition. The intelligent men of the minor peripheral churches seemed superstitious to the orthodox but were not superstitious within their groups. Their groups were smaller, their teaching was smaller. Truth in a democracy or a brotherhood may be determined by the number of its believers.

Psychological power over the style of people's thinking has the effect of establishing truth. Thus if the King has all the power, what he believes is true is effectively true in men's minds. More often, however, the mob of one's peers has the power, and if the majority of that mob believes a certain thing then it is true in its consequences for that society. This sets the underground criteria for modern knowledge too.

Bultmann thought death was not derived from sin. We had it before sins were committed. Original Sin as an inherited infection seemed absurd. But Original Sin is not absurd if the individual is group-bound. He may inherit a feud or a war or a national debt. He may have to atone for the mistakes of his ancestors who produced pollution and mismanaged economics. Today some people disconnect themselves from responsibility to past or future people. They refuse to pay war reparations or to employ deficit financing.

In the allegorical interpretation of the New Testament, mythological events are merely symbols of processes going on within the individual soul. The mythology is essentially avoided. The Kingdom of God comes to the individual soul. The Kingdom is a supernatural and religious blessing which links the individual with God. It is an experience for the soul only. The great truths of religion, then, are quite outside of society or society's history. They exist in the individual soul. The acts of an individual give symbolic expression to the kingdom within him. These acts contribute to history, and so history may become sort of secondary expressions of religious truths. Teachers who merely lecture or put on demonstrations detach themselves from the kingdom within them and try to transmit to their students only these secondary symbols expressed in the historical acts of other people. The student is far removed from the kingdom within the teacher. Jesus, however, was not a mere teacher. His life and his acts were the decisive events of his message and of the kingdom within him.

The history-of-religion school of New Testament critics have a different way of looking at religion. They consider that the culture of Christianity is an end in itself. It does not try to improve society. It does not seek self-improvement for the individual nor the development of his personal ethics. These developments are incidental to the existence of the culture of Christianity.

Bultmann's question was whether we could find the truth of the proclamation without mythology. This truth is hard for the Western mind to use, however, because the proclamation refers more to Byzantium than it does to Europe.

DE-MYTHOLOGIZING:

An individual in the New Testament is spirit, never matter. The gnostic element in the New Testament considers soul a pure celestial element imprisoned in matter. The present world of matter is controlled by demons, who therefore control the imprisoned soul. Redemption can only come as a divine gift since God is outside of matter and circumvents the demons. A more prevalent concept in the New Testament is that the spirit is never imprisoned in matter. The cause of corruption and death of the body is sin, not matter. The spirit affects matter, not vice versa.

But an individual can preoccupy himself with the needs of the flesh. Man seeks security in the flesh, that is, in materialism. But no man is ever secure in life. To preoccupy oneself with security in the material world is to lose by neglect the spiritual life.

Faith implies that the individual self is committed to God as if nothing will come from the self but everything from God. The self, therefore, is detached from the world and deals with the world as if it were not dealing with it. In the New Testament, such faith is possible only when it is faith in Jesus. Otherwise the individual has faith only in teachings transmitted by verbal language and not by Jesus' acts in the same world with the individual.

The New Testament maintains that an act of God gives man the ability to be self-committed, and also capable of freely having confidence in others; thus taking his place in history. Existentialism, however, holds that individual man through his own intellect can understand his own being, his own place, and his own effect in history.

Heidegger thought that the individual's existence as a self in a world of constant change (a world of history) produced anxiety because the self was in permanent tension between the "already" and the "not yet."

--To immerse the self in the concrete world of nature or in the social group is to reach security of emotion but not to reach an individual self--only to reach a social self. This produces a lack of security concerning the permanent self. As society changes, the social self breaks continuity with the earlier self of the individual.

--To abandon all security and commit the self to the future as an individual self produces authentic individual being but it also produces much anxiety unless, through Jesus, that self is committed to God.

Christian love is so universalized that it steps outside of history by avoiding our close neighbors, since ordinarily the theory of this love is developed by people thinking about distant things. Living action arises, however, in the interface between the individual and other individuals close to him in space and time. Neither by this interfacing nor by inner effort of the individual self can man come to intellectual understanding of the self. Self-commitment is itself a gift from Jesus. It is this gift which allows the self to abandon material and emotional security.

But self-assertion is a sin. That's why Jesus does the asserting. Self-assertion, then, is really a sin only if the self assumes it made its own assertion independent of God.

Only those who have been loved can love. They can freely give confidence to others. Therefore, we can't as a group expect the delinquent to love us if we have never loved him. Each delinquent we punish expiates our sin of not loving him. In other words, our act of punishment allows us to deny we ever sinned to him. We can further deny this sin of irresponsibility for our fellow man by giving the delinquent to a doctor or a priest, who will give the criminal love.

The Crucifixion was an historical event in the everyday life of a certain group of people. But the Crucifixion is seen also as a cosmic event for all people and all nations. The Crucifixion is an expiation of all men's sin of not loving each other with God's love nor trusting each other freely. The Crucifixion can free us from enslavement to the powers of the material everyday world if we see it as God's gift to us and not as an act of human beings trying to project away from themselves their own lack of trust for each other. That is, we would see the Crucifixion as God's doing the trusting and not ourselves proudly doing it.

The Crucifixion is an ever-present event, being undergone now by us and showing how God is acting through us. Having already undergone death today we lose the crippling fear of it.

God does not belong to history. He is not confined by time nor by any succession of events nor even by any events conceived as random. Jesus as God could not arise from the dead since he was always what he is--dead, alive, and neither. Resurrection is simply a man-view of eternal existence. Flight into Egypt or driving out the money-changers is a man-view of transient existence. In the Resurrection we no longer see Jesus as a man. We can all imagine an arrangement of aspects or events for Jesus that run from very animal-like and transient events, such as bowel movements, to very God-like and eternal events such as creation of the universe. Resurrection is simply the most God-eternal event we consider in the life of Jesus. But some man-like things occur after Resurrection, when Jesus walks again among men. Therefore, these events are not in time sequence, mounting from animal-transient to God-eternal, nor are they in logical sequence either. We can force ourselves, however, to imagine them in logical or time sequence.

In world history there cannot be a Resurrection from the dead. The Resurrection, then, is outside of ordinary history. The Crucifixion and death of Jesus was itself the victory--just as the hanging of a criminal is the victory, not the criminal's resurrection into our mythology later. That mythological resurrection is automatic and is no miracle.

The Resurrection, the life of Jesus, Jesus as Son of God, all are as if historical. Their effect on the world has been the same as the effect of such an event in history would have been.

Suppose a good man died and three days later actually arose from the dead and a few men saw him and his empty grave and talked with him and examined his horrible death wounds and saw him even ascend into Heaven after a while. But

suppose they never talked about it to others and believed that they only dreamed it. Then the effect of that resurrection upon mankind would be the same as if it had never occurred. An unreal but believed resurrection would have an effect stronger than this real and unbelieved one. Faith, not fact, moves men. Indeed, men are most moved by a faith and by accompanying acts which are most contrary to reason. For such a faith means the emotion is great although the reason is small. Emotion moves men's beliefs and actions. Reason is powerless unless integrated (and perhaps therefore contaminated) with emotion. Faith in an eternal act of truth helps to limit the contamination.

In baptism and other sacraments, therefore, we walk with Jesus now and die with him now, too, and are resurrected with him. The proclamation is the important thing--not how it happened in history or whether it happened at all. The good arises from the faith. If we prove its historical factuality or its non-eventing, we add or subtract nothing from the human effect of that belief. The preaching which was based on the event of Easter Day is itself a continuation of the Redemption.

CHAPLAINS SENSITIVITY GROUP - WALTER REED GENERAL HOSPITAL, 1966

Matthew D. Parrish

The group was one of the learning methods in a 2-week course in military hospital Chaplain work. In general the course tried to bring the students to seek experience and appropriate attitude changes through personal involvement in hospital events and personnel relationships; not by tapping some reservoir of knowledge such as a book or teacher. The goal of the group sessions was to bring the students to awareness as a group of their underlying feelings and of how their natural interaction with each other modified their learning.

After morning classes and early afternoon ward work, the 12 group sessions were held from 1500 to 1700 hours, six days a week for two weeks.

Session Number 1 was on Monday. In the Office of the Chief Chaplain, WRGH, the group met, consisting of 7 student Chaplains, 1 student nurse (supposedly as observer), 1 psychiatrist as group consultant, and 1 Chaplain (the course director) as observer.

Synopsis: In the first session, when the group discovered that the consultant was not going to tell them what to do, but only to expect them to get on with their task, the student Chaplains began to cohere and collude around their problems of a poorly structured task and a "leader" who would not lead. At the same time they explored each others dependabilities. The nurse-observer said only about five sentences, though she was well attended to even when silent. For the next four days she had the flu and was on quarters. One Chaplain, who was about 20 years older than the rest, revealed himself as more inflexibly organized and more voluable than all the rest. He was sometimes late. He skipped the second and sixth sessions. In the beginning of the sixth session, with the old Chaplain absent, the group began to call each other by their first names, including the nurse who had just returned from her illness. The group leader and the course director, however, were not called by their first names and neither was the old Chaplain. The nurse was not able to hold aloof from the group but was drawn in as a member socially and intellectually. She discussed problems with the Chaplains essentially as an equal, she revealed her emotions as clearly as they and she ate noon meals with them twice. On the 8th session (Tuesday) a second nurse "observer" was introduced into the group. The group had difficulty in accepting her as member, though emotionally she became as moved as the most committed member. The second nurse skipped the 9th session but came back for the last three. The old Chaplain was finally called by his first name early in the second week. Half-way through the 11th session (Friday) the group began to concern itself strongly over its breaking up and to mourn this event. The first nurse said she would not be able to return for the last session. The group expressed both its regret and its hostility toward her for this decision. At the beginning of the last session a psychiatrist-observer was introduced in an Army Captain's uniform. He sat back in the alcove formerly occupied by the course director and toward the end of the session the course director was brought up to sit in the circle of members for the first time. At the beginning of the session the group noted the presence of the new psychiatrist but chose to keep him out of the content of their discussion until the sessions very end. Most of the session was concerned with mourning,

though some of it concerned a summary of the work done and a recapitulation of the feelings evoked. As the sessions progressed from the 1st to the 12th, the group seemed to discover that:

(1) Though they had a common profession they did not really know each other as well as they had thought and did not trust each other.

(2) They were all afraid of their patient-clients, especially if the clients were mutilated or very sick.

(3) They had a great deal of hostility for each other and for their clients.

(4) They had some sexual feelings which were unacceptable to them - both feelings toward women and toward men - and they managed these feelings mostly by joking but sometimes by a fearful avoidance.

(5) They had a great deal of affection toward each other, the expression of which made them uncomfortable.

(6) The hardest feelings for them to handle were affection. Second hardest was hostility, and easiest of all were sexual feelings. Of course the easiest kind of conversation was jocular with no open and honest feelings expressed at all.

(7) The group became coherent initially around their common dislike of the leader.

(8) Feelings of hostility, affection or sexuality toward selected members also enabled the group to cohere at times.

(9) Communication with the course director in the group was all one way (since the director did not speak) and this allowed the group to build up a complex set of it's own feelings about him and another complex set of feelings which it imputed to him.

(10) Most of the feelings in (9) were destroyed when the course director sat as a member in the group circle, but then the feelings were transferred to the visiting psychiatrist who sat aloof. The group compared this to certain feelings for divinity.

After about 12 of these sessions the course director and the consultant held 15-minute "post mortems".

After the last group session, an hours "post mortem" was held - leader, new psychiatrist, course director, and one student Chaplain. The consultant revisited the sessions with a group process supervisor 6 times during the course.

Session Number 1

Seating arrangement clockwise: Jim, Mary, Nelson, John, Mark, J.C., Herb, Sonny, Matt (consultant), this formed the group circle with three to twelve inches between each chair, except there were about two and one-half feet between Matt and Jim. Floyd (course director) sat in an alcove about 6 feet directly behind Matt and Sonny. Exactly at 1500, Matt and Floyd entered just as the student Chaplains were sitting down and were arranging for the proper number of chairs. One chair was empty for the nurse, who came 5 minutes late. For the first 60 minutes, Matt did not utter a complete sentence, although as he entered he articulated a greeting, and during the entire session he displayed considerable facial and bodily expression - shrugs, grunts, hand gestures, smiles, frowns, and shifting around in chair.

For the first 20 minutes or so the group acted as if it had no idea why it was meeting but gradually began to show to itself that it really had a fair conception of its task of studying its own behavior. The first 20 minutes were essentially filled with disconnected utterances, the content of each having little or nothing to do with the content of what went before, but it seemed that there was an underlying symbolism which was well connected. The group tended to be tense in this time and to make comments or jokes to fill time. After about 20 minutes, Mark (oldest Chaplain) filled up a great deal of time by long harangues. The group did not seem particularly to enjoy these but did seem to like his filling up the time. The last part of the session was filled with subtle allusions against the leader, the director, the Chaplain's Corps, and the Army.

Successive Examples of Content in the First Session: After everyone was settled in their seats, a minute or two of silence ensued, making it seem unlikely that the consultant would ever organize the group's work for it. Mark (the oldest) looked around at the walls and the other students and said in a playful manner, "Is the room bugged?" Two others wondered with him. The group then lapsed into a somewhat painful silence.

Nelson: "I wonder who that emaciated saint is?" - indicating a book end with a white gowned figure on it. Two or three others looked at the book ends without much interest.

Sonny: "It's easier to confer with the unhappy than the happy. It's the people in fox holes who are dependent, who believe in God, and who need the church." Mark mentioned that he had done a lot of fox hole ministering but he drew little interest from the group.

Someone asked, "What are we supposed to do in this group?" Everyone assumed an air of innocence as if they had no idea as to why they were meeting.

About every 5 minutes someone would turn and recognize the presence of Mary, the nurse, mentioning that nurses had to put up with patients a lot more than Chaplains and wondering how a nurse would feel about the group's talk. She was never seen as anything but a woman and a nurse - 2 stereotypes. Mark, at one point, called her a sex symbol, rather jokingly, and a couple of students implied that she was pretty.

Mark launched into three or four harangues - at first concerning how much experience he had, and then how he was not married and therefore different from the rest, and at last how bad certain people were. "Once a SGT said, 'I guess you couldn't understand all I've been through.' I pointed down to my brown shoes and said 'I was in combat too...' The SGT practically kissed my feet but I said 'Don't apologize, I've seen punks like you before.'

Commanders should not rate their Chaplains.

But it's even worse if a Chaplain rates the Chaplain.

Doctors get a hundred dollars a month extra (a couple of sidelong looks at the consultant). The Chief of Chaplains refused extra money for us.

After one hour's silence, the consultant, Matt, said: "Can the group now reflect what it has learned about group behavior in the past hour?" -

We talked about our common field, the church and problems of the ministry.

Consultant: The first thought was "Is the room bugged?"

Yes, we not only don't trust the world but don't trust each other... We didn't want any Chaplains to rate us...

As the group broke up most of the students oriented themselves around Mary and graciously invited her to return tomorrow.

Session Number 2

Mary's chair remained empty through the period. The consultant explained that she was sick. Mark's chair was also empty. Students explained that he worked all last night and would work tonight too. Members took turns discussing thoughts about their place in the profession and how the profession allows them fulfillment of personal needs. Mostly Herb and Sonny did the talking. Nelson chewed "chcoz" all the session because of heartburn.

Consultant (near end of session): We seem to be expecting to come to some great conclusion by intellectual reflection upon the past and the distant... By dealing with the here and now we might exercise other functions in ourselves.

Session Number 3 (Wednesday) - All Chaplains present; Mary absent.

There was much discussion among the students of how frightened they are of the very sick or of the amputees. Herb: "I almost vomited." The group tried to examine Herb's anxiety and discovered that nearly every member felt the same.

J.C.: "But the group is not looking at the relations we have among each other." Mark immediately launched into a long piece of enthusiastic advice to Herb and went on to explain that he had more experience than anyone else in the group, until someone reminded him that as far as experience with this group went, he had one day less than anyone else.

J.C.: "Herb's problem we consider as a thing outside the here and now and as just nutty enough that we feel justified in working entirely on it and avoiding what we are doing to each other." The group digested J.C.'s idea in a long silence.

John: "It is a common experience we have here. The group has it."

Herb: "It is a different experience for each of us and each of us feels it with a different intensity."

Session Number 4 (Thursday)

Mary was the only member absent.

Early in the session Mark challenged the consultant very vigorously asking, "Are you Catholic?", and then insisted vigorously that he had a right to know and that he must be answered. The consultant never did answer and Mark lapsed into a sullen attitude for most of the session. The other students had only a slight tendency to come to the consultant's defense during this attack, but afterwards they interacted with each other, showing more personal consideration than usual.

In COL Morgan's supervisory session with the consultant, COL Morgan reported that Mark was insisting in morning classes that the last group session should be a practical application group showing how to apply what had been learned in the group sessions. In addition, all students think that the consultant is very rude for the way he walks out of the sessions at 5 o'clock without saying where he is going. They complain of the consultant's lack of leadership and remark that he looks like he may be drunk.

Session Number 5 (Friday)

Present: All the Chaplains but no nurse. Throughout this session the Chaplains would frequently approach an interpersonal interaction and after 10 seconds of it they would let someone (usually Mark) steer them on to a philosophical subject. Example: "At a religious retreat the relationship is more vertical than horizontal, that is, more between man and God than between man and man."

Consultant: "Here it seems more like an atomic plant. Uranium bars are each manufactured at a different time and place with slightly different tool marks; that is, the vertical history and the relation to the factory is different. But when several bars are brought close together, they heat up from their horizontal relationship with each other. They may explode. We group members are afraid of an explosion every time we express feelings together.

Herb said he thought that Sonny was probably not a member of the group because Sonny kept talking and thinking of something else outside the group, then the group suddenly plunged into a detailed discussion of whether Sonny is really too concerned with something else. Consultant: "If I say I don't like you because you wear GI glasses - the group jumps in to prove that they are not really GI glasses, rather than face the fact of my disliking someone."

Mark suddenly began to explain that we are all too stupid with intellectuality and with explanations rather than with feelings. Three or four group members seemed to let him make this discovery for them even though they knew it all before.

In this session there were only three or four, ten to twenty second episodes of direct emotional relation between two or three persons. The relation was mostly anger. The group, however, was cemented by these reactions. The group concluded that a group is brought together by:

(1) Working on a common goal.

(2) Having between its members emotional reactions which are well perceived by the group as a whole.

Session Number 6 (Saturday)

All Chaplains were present except Mark. No nurse was present at the beginning. Up to this point the Chaplains had always called each other by their surnames and their title - "Chaplain." This session began by one Chaplain's telling another that he didn't like his own first name so had always been called Sonny. Another one also complained about his name.

Consultant: "Possibly we are seeking to use different names here."

Member, "Yes, why haven't we used first names?" At this point all told each other their first names; then they fell to wondering if they could have told each other their first names in the presence of the senior member, Mark.

At this point Mary (nurse) came in about 10 minutes late. This was the first time she had appeared since the initial session. She sat in the empty chair. J.C. put his hand on the shoulder of her chair, bent over her and asked what her first name was. She stated that it was Mary while looking

her communication to Sonny, who was directly across the room. The consultant asked the group to review in their minds what they saw as the process of getting Mary introduced into the group today.

Essentially they agreed that J.C. spoke as the group's mouth when he hoveringly "shoulder-touched" Mary and brought her into the group on the same first name basis all other members had just received. Sonny acted as the receiving face of the group because he was on the opposite side of the circle. Jim was beside Sonny, but Mary had eaten lunch with Jim the day before, and if she had talked directly to Jim, it could mean that she was telling her first name to Jim to use forever and possibly not telling it to the group at all. The same would apply if she addressed herself to J.C., who was hovering over her. As it was, she told her name to be used by the group but not necessarily by each individual when separate from the group setting.

When her name was known she turned in her chair slightly away from J.C., as if he were now being intrusive. He respectfully took his hand from the chair shoulder. The group wondered whether it could at this point accept a completely new member. The group boundaries seemed impermeably now.

There was not much heating up of the critical interpersonal mass, though there were some allusions to Mark's absence, as if he really couldn't understand some things we were now doing; probably couldn't tolerate first names.

Herb asked the consultant his first name and it was readily given as Matt. One member then asked if Matt stood for Matthew; another member also said the word Matt. The group seemed to pass the name around among them. "Would it be right if we called him by his first name, or should we call him consultant?" Mary: "I am a 2D LT and I always call him Matt." Still the group itself backed off from addressing the consultant by any name face-to-face. Nelson made some long harangues in the third person while continually using and savoring "Matt." In part of this harangue he also savored the name Floyd (the director's name). They decided that Floyd is even more distant from them than Matt.

Consultant interpreted the group's name gathering maneuver: "When a person tells someone his name he usually touches, looks and speaks. To what parts of the second person are each of these maneuvers directed?" Jim, who closely facing Matt, said, "Shake <u>hands</u>, look at <u>eyes</u>, speak to <u>face</u>," and suddenly with a glad expression Jim reached out and shook hands with Matt (though Matt didn't expect it). Jim, "First I look at the hand and then the eye." At this point it was evident to the group that the group had even touched the consultant through Jim and had unwittingly completed their ritual for getting more familiar.

Post-Mortem: Mary, Floyd and Matt present. Floyd: "No one was <u>required</u> to come to this Saturday meeting, but only Mark stayed away." Floyd decided not to do an application group but to consider it for the next course. He thought that if a visiting Chaplain came into the group now, we could see whether the group could accept another member temporarily.

Session Number 7 (Monday)

All Chaplains were present, except Mark, who came half an hour late.

Consultant arrived five minutes late to find the course director in the chair the consultant had always used. The group was in a friendly discussion about course matters. As consultant entered, the director retired to his back seat. As the group began to wonder what it should talk about, consultant asked what the group would do if the consultant didn't show up at all. Would it be able to continue with the one and a half hour task? Ten minutes late Mary came in. No one rose. Explanation: "She is in uniform and therefore more like one of us." Mark entered about half an hour late: "Don't ask me where I've been. I couldn't help it." He then launched into a ten minute exposition of how he has been hearing confessions, etc.

The group tried to discuss Mark's first name. Herb said he wondered whether to call him Marius (his formal name), but the subject was quickly dropped and Mark went into another long exposition. After a while Sonny, who was sitting next to him, stopped him and questioned whether Mark had not missed too much by being absent at the group's most significant meeting Saturday. Other members asked Mark to come on and join in the group in ernest. Later Mary remarked, "It was very relaxed here before you came in."

John: "Yes, my palms are sweating now." Nelson then reached out his own palm for Mark to touch. Mark found it dry and seemed reassured therefore that the group was not as a whole group against him. Consultant called attention to the fact that Mark had now been touched in accordance with the usual pattern in this group of asking the first name, touching the person, savoring the name by repetition. This was true at least for Mary and the consultant. The group considered this reminiscent of apostolic succession by laying on of hands as a group-joining ritual.

Mark had said just after his touching that his mother never called him Marius but always Mark. After this the group called him Mark, gingerly at first but then with ease.

Post-Mortem (Mary, consultant, director): Plan for Wednesday group session: Mary is to come in 10 minutes late in order to assure that the Chaplains get into the room if they are still standing around outside. Consultant and director will come in 10 minutes later (3:50). Question: How will the group get on with its work without the staff?

Session Number 8 (Tuesday)

All Chaplains were present from the beginning.

Anne, a nurse friend of Mary's, who had been assigned to come to the group from the beginning, finally came for the first time today. Mary and Anne arrived two or three minutes early and sat together in a corner. The

group asked Anne her last name. Mark came in one minute late and started one of his long speeches about his work. The group said they would limit him to five minutes. He limited himself to one minute and ended up by asking Anne her first name. John and Nelson were anxious to know how she spelled that name, one because he had had a fiancee of that name, and the other had a wife by that name. No one touched Anne in this session however. At this point Mark swung around to the director (Floyd), who was sitting behind him, and asked him to sit in the circle of the group. He said he hoped to bring Floyd into the group so that the group could get rid of its hostility toward him. Floyd, however, did nothing and said nothing.

It became apparent that certain chairs in the circle had taken on a specific meaning. The one the consultant usually sat in had a different meaning from the ones which faced across the room toward the director, or those which had their backs to the director.

It appeared that the group was a symbol-making system which took words and chairs from the culture and gave them a specific significance for this group only. This symbolization seemed to be a part of the group's becoming a coherent group. Thus, there was developing a language of words and manners and a reshuffling of architectural and individual significances. The group decided that Anne was <u>not</u> really a member because:

(1) She was not present at the first group meeting.

(2) The group had not seen several sides of her - several roles.

(3) The group had not seen her come back to them in their normal diurnal rhythm of meetings.

At post-mortem Anne said that she felt under stress and ambivalent.

<u>Session Number 9</u> (Wednesday)

All Chaplains present; Mary, the only nurse, arrived 10 minutes late; director and consultant 23 minutes late. The group did not really go into the room and close the door until Mary arrived.

Mark talked a great deal about the director as "The Ghost." Even after director and consultant entered, Mark talked very easily as long as he was sitting in the chair that had its back to the director. Jim, who was in the chair across the room and facing the director, induced Mark to change seats with him. Mark then discovered that he could not continue to deride the director, because he could now <u>see</u> him. J.C. at this moment said: "I feel much relieved since Mark moved there." It became apparent that J.C. was the person most directly facing the director, and that he had been acting as a feed-back apparatus between Mark and the director. Mark had watched J.C.'s reactions to the reactions of the director concerning Mark's derogatory comments about the director. Mark, it appeared, could feel paranoid about the

director behind his back but he depended on J.C. to keep him straight emotionally as to what was going on behind his back. Later, when Mark was facing the director, he was far less inclined to be paranoid. J.C., on the other hand, remarked, "I couldn't be myself when I was such an apparatus... We can't be completely ourselves when we play the role of Chaplain on the ward or in the pulpit. We are then a sort of feedback apparatus or perhaps an amplifier or transformer between God (or morality) and Man."

The group revealed that it felt more comfortable and friendly with the consultant and was able to understand and to help define some of the consultant's own emotions and opinions. However, the group now turned onto the silently observing director all the hostility which it once had against the consultant. Consultant requested that the group consider why it had all this hostility in the first place.

Session Number 10 (Thursday)

All Chaplains were present; 2 nurses were present.

The general discussion revolved around roles. In the first part of the session the group would spend 5 minutes talking with and about Anne concerning whether she was a member and then the group would analyze its feelings about Anne. One member would give his feelings; another would modify this and add his own. After 45 minutes, Mary and Anne changed seats with each other - Mary moving from an "11:00" position to the "3:00" position. At the same time Mark and John changed seats - Mark moving from "12:00" to "2:00", thus Mark and Mary still ended up sitting beside each other.

In the course of conversation about how anxious people felt, Herb managed to reach out and touch Anne's palm to see if it was sweating.

Sonny: "Now we've touched Anne."

Herb: "Oh, am I just acting for the group again?"

Sonny: "Yes, you're bringing Anne in as a touched member."

The group discussed the feminine stereotype... It's OK for women to cry. If there were no women present would a man take a feminine role? It was recalled that Mark did a "fan dance" in an earlier session when he demonstrated how some men were curious about his appearance with no clothes on. The men were embarrassed to tell the nurses about this.

Mary: "You wouldn't have mentioned it if you didn't want to tell us." The group went on and told of the episode saying, "I guess it's hard to embarrass a nurse." The nurses were peeved at this and said that they thought it was another stereotype, this time about the nursing profession.

The members searched their feelings about how they reacted when sitting in various chairs. The only strong "transformer position" was the seat facing

opposite Floyd, the director. Both Mary and Anne expressed discomfort at sitting beside Mark because he kept drawing a stereotyped sort of sexual attention to them.

Session Number 11 (Friday)

All Chaplains were present; two nurses were present; the consultant did not say a word for the first 60 minutes.

The group began with Mary's announcement that she would not attend the last session of the group (tomorrow) but that Anne would. The group discussed its feeling toward Mary, at first in terms of affection but this was laughed off quickly. There was anger at her leaving after the group had made her an important member. The group was especially angry at her not staying till tomorrow and "going down with the ship." The hostility was sincere, with very little attempt to laugh it off.

Consultant remarked that the sex-symbol attitude seemed absent now from their thoughts about Mary. The group said it felt that sexual feelings toward her would now amount to incest, "She is our sister." They thought that the "sex symbol" was a stereotype they applied to someone who does not really belong to the group. Anne's palm was touched again by a member. A little while later Mary's hand was touched and as the group broke up almost every member touched her or plucked at her somehow.

A conversation among three members brought out that if Anne should not show up tomorrow the group would be made more angry at her than at Mary, who at least told the members she was going to be absent and therefore allowed them to express their special feelings about it and to pass these feelings around in the group modifying them as time went on.

Session Number 12 - Final Session (Saturday)

All Chaplains were present; Anne was present but Mary absent; arrangements were made ahead of time with the director to have CPT Wong, a psychiatrist, observe the group today.

Consultant and CPT Wong entered when about half the Chaplains were assembled. CPT Wong sat behind the consultant's usual chair but Sonny was in the consultant's chair. The consultant walked around the circle with seeming uncertainty about where to sit but no one would allow him to sit anywhere except in the empty chair between Sonny and Anne. The consultant refused this and finally got the reluctant Sonny to move next to Anne who was for the first time wearing civilian clothes in the group and seemed unusually pretty. The group appeared to be disappointed that consultant and Anne did not sit together as if they had expected great good to come out of such a seating arrangement. The group began talking on the subject of its breaking up. The group then tried to praise Anne and to express how much the members loved her.

John: "But this is a substitute for loving each other." The group then expressed its uncertain feelings about men having very much affection for other men, as if perhaps there were something homosexual about it. They finally concluded, however, that real homosexuals seldom have much true affection.

J.C.: "It seems that our strongest taboo is the expression of affection because a person might get hurt if he showed affection and then was rejected. The second strongest taboo is the expression of hostility because it makes other people dislike the person who expresses it. The weakest taboo seems to be the expression of sexual feelings." Other members thought that they sometimes took to seeing someone merely as a sex symbol when they were about to feel very tender toward the person. Sexual feelings were then a way to avoid tenderness. Furthermore, courtship is a more familiarly stereotyped pattern of behavior than is the expression of pure affection, thus sexual behavior is usually more predictable and manageable.

About half way through the session the director (Floyd) changed seats with CPT Wong. This put the always silent CPT Wong in the alcove where the director as "silent observer" had sat through all the previous sessions. A member remarked that CPT Wong seemed like a ghost. Another member objected the group had too much to do to talk about this new observer, in fact the group had mentioned his presence in the first minute of the session but had decided they didn't have time to bother with him. The group now wanted to vote whether the director should join the group circle. Some objected to voting, however, and considered such action an after-the-fact formal expression of individual views. "Some people vote opposite to what they desire. They do it for political reasons to make the right impression as an individual. Usually they do it after they are sure the group vote will go against that individual vote of their own. Group decisions are usually made before voting." Finally the group, in a spontaneous expression, asked the director to come into the group and suddenly discovered that there was an empty chair all the time, which the group had pushed back in a niche near the "transformer" seat. As soon as he sat in the circle, the director became easily conversational with the other members. J.C., who was sitting beside him, said he felt no difference with the director sitting in the group. "Chaplain H was always a part of the group to me." Members still called him by his last name. Anne was unable to remember his first name, although the consultant had mentioned it earlier in the session. Mark: "He used to work for me and I always called him by his first name, but its hard to do it now." Two other members "practiced" Floyd's first name by bandying it around while they talked of their uncertain feelings about using it. "Now the real God is CPT Wong and Floyd is a Messiah who has come among us and is a human being."

The trinity now seemed to be CPT Wong, the consultant, the director.

The group agreed that Anne was never the secured-in member that Mary was, but they appreciated her going down with the ship. Anne remained very silent, seemingly with a lot of feeling but fighting that feeling as if she were perhaps about to cry. In the last 10 minutes of the session the group began to fragment and it was easy for three conversations to go on at once. John: "The group is trying to break up ahead of time." Mark made a little speech of appreciation toward the consultant. Some other members echoed this without feeling it really very necessary. At the session's end, Anne went out quickly as if she wanted to be alone. Later she said that she had cried as soon as she was alone.

Post-Mortem: Director, CPT Wong, consultant and J.C. remained and discussed the group for one hour. J.C.'s opinions:

(1) The group should meet for one and a half hours per session.

(2) The group should end the course (the diplomas were given out before the final group session).

(3) The group should have nurses in it.

(4) The group should have the director as an observer.

(5) CPT Wong's coming in as an observer on the last session made very little difference one way or the other.

Consensus was that learning for these Chaplains had occurred mostly on the ward work and in the groups and not so much from the lectures, although the lectures had provided some concepts which could be worked over in the group and in the ward practice and made a part of experience.

It seemed possible that "application groups" would be most useful to help the student Chaplains to apply their conference experience to their everyday work back home. These application groups could be a few sessions on the last days of the conference and probably should be conducted by a separate consultant.

It seemed that one hour sessions should be tried out with two, one hou sessions on the first day of the conference.

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Revised 1/12/78

ANNOTATED BIBLIOGRAPHY FOR COMMUNITY MENTAL HEALTH THEORY

Matthew D. Parrish

1. William Graham Sumner (1840-1910): Folkways (1906), Dover Edition, 1959 Section on "The Mores".

A condensed version of this is in Parsons, Shils, et al (eds): Theories of Society, Free Press of Glencoe, Illinois, 1961, pp 1037-1046.

--The effect of customs upon individuals without their necessarily being aware of it. --How customs may be changed permanently if proper rituals are instituted or if seemingly similar customs are substituted.

2. Charles Horton Cooley (1864-1929): Human Nature and the Social Order, (1902), Schocken Books, 1964, chap 1, "Society and the Individual", 5 "The Social Self, 1", 6, "The Social Self, 2".

--How "human nature" forms only in the context of the group in which the individual lives. This human nature is the illusion of what the individual thinks others think of him. --The "primary group" of direct face-to-face interactions determining the depth of emotional life. The group theory is somewhat parallel to Max Weber's ideas.

3. George Herbert Mead (1863-1931): Mind, Self and Society, University of Chicago, 1934, 1963. "Mind", pp 42-135; "The Self", 135-226; "Society", 227-336.

--Language is necessary for the development of a sense of self. Thus, animals and very young children have no sense of self as adults understand self. The self is formed out of role-taking, role-changes and two-way communication with others. The socialized individual has to be capable of being several things at once. He is different in different social contexts. These contexts are somewhat parallel to Alfred North Whitehead's concept of organism.

4. W. I. Thomas (1863-1947): "The Definition of the Situation", in E. H. Volpart (Ed): Social Behavior and Personality, contributions of W. I. Thomas to theory and social research, NY: Social Science Research Council, 1951. Chapter on "The Definition of the Situation".

--Condensed in Theories of Society, pp 741-746. --When men define a situation as a real it is real in its consequences. A person's behavior is determined by (1) his attitudes and habits from previous experience and (2) his own definition of the present situation.

Behavior usually consists of security operations, adventure operations, recognition operations, or mastery operations. The mastery operations consist of the individual's response to challenges, the response which builds for him a pattern of character and time-extended selfhood. This "challenge and response" is parallel to Arnold J. Toynbee's notion of how whole civilizations and societies are formed as cohesive historical units when they respond appropriately to challenges from nature or from the aggression of other societies.

5. Edward Sapir (1884-1939). D. G. Mandelbaum (Ed), University of California Press, Berkeley, 1963. "The Unconscious Patterning of Behavior in Society", pp 544-559. "Cultural Anthropology and Psychiatry", pp 509-521.

--The preceding authors brought out the notion that the individual's behavior and his type of feeling and thinking were determined by the small group in which he lived, and the situation in which he found himself. Sapir shows that all of this sort of character is still within the bounds of the culture which contains these social groups and

situations. Persons of widely different language and culture may see the world quite differently. Most of what psychiatrists and psychologists up to this time have called universally human was really cultural. In some respects the cultural mores and the language constitute a matrix into which the pliable infant is poured and from which he gains the form of his psyche.

6. Benjamin Lee Whorf: Language, Thought and Reality, Boston: M.I.T., or John Wiley and Sons, New York, 1956-59. "The Relation of Habitual Thought and Behavior to Language", pp 134-159.

--The pattern or the grammar of an individual's thought is determined by the language he speaks. Language determines his approach to problem-solving and accounts for many of the differences in craftsmanship, human relations and industrial skills between widely differing cultures.

7/12/74

TEACHING WRITING (May, 1967)

By Matthew D. Parrish, M.D.

For essentially the next fiscal year I am supposed to be editor of the Army Medical Journal in South Viet Nam. At the APA meeting in Detroit beginning May 8th I talked to quite a few editors, publishers, and writers. In general, they seemed to think the great proliferation of writings has made it impossible for individuals to read all that they are supposed to read or that they allege that they have read. Jurgen Ruesch in particular thought that people were getting more direct access personally and orally to more people and especially within their own profession. This is in contrast, say, to the year 1800, when important communications about one's profession had to be written either in letters or journals. Jurgen Ruesch seems to think there is a great deal of lore being transmitted by word of mouth. Apparently most of this goes on within particular institutions, such as universities or hospitals, and then representatives from the institutions transmit it further in their travels. Hal Rosenthal, who is editor and publisher of Basic Books, and also Martin Grotjahn, the California psychiatrist, seemed to think that Americans today were rather poor writers, probably because they no longer studied Greek and Latin. When they do study a foreign language it is usually Spanish or French which they use conversationally more than they use for putting their thoughts into a foreign but well ordered prose.

Most of the people I talked to seemed to think that the real literary-technical writer belonged to an elite group and had to be selected for further graduate training out of the masses of medical students and residents who were never trained to write English in their basic schooling. The general attitude of modern schooling--carried on more by students than by teachers--develops facility in a sort of visceral, salesmanlike, rough vernacular, oral expression. They speak and write the language of the close group rather than the more formal language of the grand culture of the U.S. or of the West.

But how are we going to train these elite writers? It seems to me that within every publishing institution, such as a research institute, there should be a position for a full time writer-editor-teacher who can get together with the groups of workers who do write technical things and by collaboration develop a better organized and more literary, more interesting, and more readable article. Indeed, I think residents in training from the first year on should learn to work with such a person just as they learn to work with a psychologist.

A couple of the editors told me that they sometimes condensed and typed over a too lengthy article and then sent it back to the writer. The writer then, strangely enough, believed that this was the way he had written it in the first place--that this short condensed version was really his own. My notion is that the original article he turned in was probably a collaborative, somewhat plagiarized production in the first place, and the editor merely became another collaborator. In fact, I think that 99% of writing is plagiarism and/or collaboration, for the good writer participates in ideas and feelings from the people he works with. He sifts and organizes ideas, and then runs them out for his colleagues to comment on piece by piece. From these new comments and feelings stimulated by his conversations he constitutes his ideas and finally presents them for publication.

Going over the variorem editions of some Shakespeare plays led me to think that a great deal of the final polishing in those plays came from Shakespeare's interaction with the actors who had to play them and from the audience's response to the first few presentations. In fact, the particular word in a line that comes down to us may not have been written by Shakespeare at all, but may have been heard that way by the first listener who took it down in shorthand in order to pirate a quarto or so. Of course, Shakespeare's plays were not so much a folk collaboration as were some of the old ballads or epics. Still, I don't think we should feel too bad about a folk collaborative article coming out of a research institution. A good writer then might be one who could pick up the best of the folk interaction that goes on about a technical subject and with or without the help of a teacher-editor get it into interesting, witty, and clear English.

Well, Jurgen Ruesch did say that the University of California employed persons similar to those teacher-editors I was talking about in order to help their residents write. I think that he said they have one for surgery, one for medicine, and one for psychiatry.

One of the ways I try to teach residents to understand basic literature is to assign three articles to a trio of residents. Each person of the trio reads two of the three articles, but no person reads exactly the same two. Thus, there are always two residents who have read any one article and there is one who has not read that article; therefore, he has to be taught by the other two. When the trio meets by itself and later with me, they each learn-digest the three articles (which are usually closely related). Later, one of them presents the three articles to a group of three or four triangles, and after two or three presentations they are supposed to have a break and interact as they please about the articles.

I sort of believe that academic learning occurs through reading, speaking, writing, acting, and dreaming. If one reads an article and does not pause to mull it over in his mind, to dream about it, to fit it in with his own highly personal recollection and feelings, then it has little meaning to him and he soon forgets it. If he has to express orally his own feelings and the author's, then his tongue and the arranging function of his brain gets the practice of dealing with those ideas, and he learns a great deal more. He learns still more if he writes about what he has written, even if it means only making fragmentary notes. He learns even more if he can get his body to go through some pantomime or dramatic interaction with other people on the subject of the article he read. For instance, a reader learns better what Shakespeare was up to in Macbeth's encounter with Macduff if he squares off with another reader and acts out the meeting and the swordplay as he or someone else reads through the actual words. This acting gets the material learned into many organs of the body and not just into the brain.

The highest truths seem to be those ideas which are extracted out of the facts of everyday life, out of events of historical becoming, and set into the grammar of ordered being. These truth ideas are written in a language which is consensual for the total Western culture and tends to be valid for all times. These truths constitute the eternal principles of science or of

jurisprudence or of art. The "untutored events" from which these truths are drawn are often highly personal local encounters among people and things which would not make sense outside of the time and place in which they occurred except that someone interprets them in the light of the needs of a larger group or culture. At UPAIP or in a hospital where actual cases are being worked with, the workers talk to each other in a patois of their own, letting ideas rattle around among the various workers in a crazy disconnected fashion at first. When a worker organizes these ideas into a form which becomes understandable to a larger group, he also loses some of the facts, some of the flavor of the actual persons and events involved. These persons or events becomes types which to some extent can be easily understood by any mental health worker. At this point, then, it can be published in a professional journal. Well, I think we need both facts and truths in our teaching and the good teacher or writer is he who can put across something of both.

A MARATHON GROUP--APRIL 29-30, 1967

Matthew D. Parrish

Therapists: Vince Sweeney, Mark Lewin, Don Carter, Matt Parrish.

Members: Sixteen persons (half women) but none were married couples. Age range was about 21 to 60. There were 2 court counselors, 2 school counselors, 2 Red Cross nurses, and the rest were ordinary laymen.

The people met in a room about 13' x 14'. The floor was covered wall to wall with mattresses. Each one brought a blanket and a pillow, and almost all were stockingfooted. Four candles provided light at night. The room was on the second story of a farmhouse amid fifty acres of meadow. The three meals were eaten downstairs in small groups clustered around low tables. Some people sat on chairs, some on pillows, some on the floor. Each meal took about one hour. Other than for meals and for the bathroom, no one left the group meeting room. The group session began at 9 o'clock on a Saturday morning and ended at 1 o'clock Sunday afternoon. The members slept on an average of five hours each. Never more than half the group was asleep at any one time.

There seemed to be about four different modes of emotional reaction. These tended to occur in definite succession and to repeat cyclically:

(1) Jollity
(2) Sexuality
(3) Hostility
(4) Tenderness
(5) Poetic expression of group emotion.

This sequence of modes was repeated in three or four hour cycles. Sometimes sexuality was skipped and sometimes poetry was left out of the cycle. It was easy enough for the group to talk in platitudes or to make jokes. This merged into sexual innuendoes such as commenting on another person's looks or such as utilizing one's femininity or masculinity to get the opposite sex to do something. A lower numbered emotional mode, as above, seemingly could cover up a higher number. Thus jollity often covered up sexuality or hostility. The smile that covered up hostility sometimes had in it a gritting of teeth or a suggestive leer or perhaps a seductive come-on. It was hard for the group to reach as far as honest tenderness and even harder to render their feelings by a broad development of total feelings in a picturesque, poetic expression.

Four channels of communication were evident:

A. Intellectual verbal.
B. Gut verbal.
C. Non verbal (changes of voice, gestures).
D. Drama.

Each mode of emotional reaction could be expressed by all channels of communication. For instance, the hostility mode expressed in the intellectual verbal channel would amount to: "I am irritated with you." In the gut verbal channel: "I'm mad at you." These words spoken with jutting jaw and glaring eyes would

involve the non verbal channel. If the angry person picks up an imaginary club and swings it at the other person's head, who holds up his hands to fend it off excitedly, and then responds with some other dramatic gestures himself, then this involves the drama channel of communication.

It seems that in most group therapy there is too much intellectual communication. Channel D is probably the most important for therapy and Channel A the least important, although a certain amount of all four is essential. Indeed, Channel D allows emotional expression and understanding to occur in all parts of the individual mind. The hands are part of the mind.

Example Using All Channels and Three Modes

Early in the group session a 60-year old woman said that she was always doing favors for everyone, working overtime for no pay, answering phones for other people, going out of her way to do things for her daughter which the daughter could easily do for herself. She had been in individual therapy for a month without improvement in this problem and had been in group therapy for ten sessions, with the groups talking a great deal about her problem. She still did favors for anyone who asked her.

At this point one of the therapists, who was lying on the opposite side of the room from her, said, "Jenny, that soft spot near you looks inviting. I wish you would do me a favor and carry me over to that spot." Jenny obediently arose to comply, but she couldn't figure out how to lift the therapist. Another therapist stepped in and helped her while she laboriously dragged the limp therapist across the room and laid him gently on the soft spot. He now took up so much room that she had no place to sit down. He merely lay there and demanded she put a pillow under his head, which she did. At this point another therapist said, "Jenny, you have just been had. You are a sucker." The group partly laughed and partly sympathized, agreed and talked at some length about Jenny and her problem. Meanwhile, another therapist said, "I don't want this guy lying here. He's taking up part of my place, too. Let's take him back, Jenny." The supine therapist objected, saying, "I'm now very comfortable." Jenny was in a quandary, not knowing which therapist to do a favor for. She finally dragged the supine therapist back across the room. The third therapist then said, "Jenny, you have just been had again." The supine therapist, complaining that Jenny had moved him to a place he did not like too well, jumped up and sat attentively by a woman who had been saying that she would not do anything like that for him. He made gestures of rejection toward Jenny.

Following this, the group decided that during the next one and a half hours till suppertime Jenny should make a point of refusing to do anything for anybody and get a lot of practice in living for herself. At this point people began asking Jenny to pass the ashtray, to bring a drink of water, etc. Jenny would generally start toward complying but then would check herself and say something defiant. Even after the meal and throughout the rest of the group session, members continued casually to ask Jenny for favors. She did only what specifically pleased her.

The Use of Space

When twenty people first crowded into the room, it appeared that they would never be able to fit. There was no space in the middle, and everyone was evenly scattered around the room. After several hours there was a great empty area in the middle, and the members were closely arranged against each other along the wall, by now unperturbed by these slight bodily contacts. Later on, the space in the middle would disappear as the members stretched out across the room, touching feet to feet, or at other times they would draw away from their neighbors when the group was in a more hostile mood.

A Year's Adventure at WRAIR - Psychiatry

By

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This is a summary of the work from February 1966 through February 1967 at the Department of Psychiatry, WRAIR.

I. Ward 108

This ward at Forest Glen quarters a group of 8 to 20 soldiers on patient status who were formerly NP patients at WRGH. The work on this ward concerns itself with:

(1) Getting back to duty a class of patients which is usually quite difficult to handle in a hospital. Most of these patients had been diagnosed in some post or camp as psychotic or as severely neurotic. Later, at WRGH, they appeared to be character disorders--perhaps because their severe illness had subsided or perhaps because the diagnosis was only due to social pressures which hospitalization relieved.

(2) Getting a cohesive group of staff and patients to work together as a community in which each member has nearly total access to every other member, and in which the therapy is considered to derive about equally from the patients, the staff, the architecture, and the "political constitution" of the ward. Furthermore, the therapeutic forces are seen as affecting patients, staff and the non-human environment.

(3) An opportunity to examine a living and functioning ward group to determine with "political science" methods, as well as psychological methods, th "constitution" of the community, the power structure--formal and informal--the effective and non-effective types of leadership.

(4) The application of certain operant conditioning and learning principles to the motivational, attitudinal and characterological changes desirable on the ward.

The ward was begun January the 1st, a year ago. For 12 months the ward was managed by a psychiatric resident under supervision from WRGH, and with consultants from WRAIR. Since this ward continued in some respects the milieu principles developed by Dr. Kenny Artiss, he also was brought in as a consultant.

Since the first of January 1967, however, Captain Art Colman of WRAIR --psychiatry has acted as the ward officer and a WRGH psychiatric resident has been his assistant. Art came to us with considerable training in the therapeutic community as originated by Drs. Tom Main and Maxwell Jones, and passed on through Dr. Harry Wilmer to Art Colman in the San Francisco area. Part of Art's work was done at San Quentin. Since he arrived here knowing very little about operant conditioning, he spent almost the entire autumn studying with such people as Drs. John Boren, Israel Goldiamond and Hal Cohen. His teachers seem to think that he is quite an expert--considering that he is a psychiatrist--and Art himself says he never learned so much, so fast.

Art intends to stay on the ward a year or so, while a new resident rotates in about every four months.

One of the interesting problems on this ward is that it is set up to operate under rather honest, democratic conditions, but the soldiers who occupy the beds on this ward have generally gotten along by subverting or manipulating authority. Now, when they themselves are made the authority, then who to manipulate or subvert becomes quite a problem. They would seem to be against themselves.

Last year a system of rewards was set up so that if a soldier performed certain good works, he earned a number of points which he could then spend to get a pass or some other special privilege. The soldiers turned out to be much more comfortable with punishments than they were with rewards, and almost imperceptibly manipulated the staff into dealing out punishments in the form of demerits. There was even some tendency to compete with each other, to see how many demerits one could earn and then wiggle out of.

I hope that all of you can, a couple at a time, visit this ward for a few hours at a stretch. If you come early in the morning, you will find that all the people who live on this ward are dressed in fatigue uniforms, just as you see Art sitting there at present--the only one of us in real soldier clothes. Probably every member will have earned a point or two by merely getting out of bed, and a few more points by cleaning up the non-human parts of the ward. Eventually the whole ward community, including staff, soldiers, and visitors have a meeting. A lot of feelings and ideas turn up. The soldiers then split up into two groups of their own and work up certain topics which they give in a written or verbal report to the total group. The soldiers thus practice formulating their ideas and needs --putting their feelings into words which are consensual and which later draw appropriate effects from the community. It is hoped that this practice will help them to effect somewhat more of their needs through honest rational action instead of impulsive or subversive behavior. It is apparently becoming more imperative that the soldiers of the modern Army be able to put their thoughts and feelings into rational order rather than into gross, impulsive acts. (It is even necessary to be literate.)

Following the writing, there is a critique and then during the rest of the day there are further meetings, work-groups, etc.

Art and his staff have found that they must react to the verbal protestations, threats, and plans of these soldiers in quite a different way from their reaction to the talk of their colleagues or of ordinary soldiers living in a hospital. When the soldiers on Art's ward speak in strong language, threatening to go AWOL or to fight, or perhaps, on the other hand, seeming to cooperate nicely and to promise good work--this talk almost never means that there is going to be any action arising from it. The most common way to get some uncomfortable action out of such words is for a staff member to believe these words at their face value and by an expectant attitude to "force" the soldier to perform what he has promised. Sometimes I have thought that these impressive words were like the impressive antlers of the stag. The stag carries about his towering antlers in a spectacle of power, but he never expects to use them in actual combat. When forced into a corner, however, he does have to use them.

Another characteristic of the soldiers on Art's ward is that they respond to group therapy by disrupting the ward. In the past month or so, their group therapy has consisted of sitting down in a group with a single doctor as therapist, but with other staff members occasionally participating. Once a week they have also had a well organized psychodrama session, conducted by Col Brick Murray. The psychodrama itself goes off very well, as does the group therapy, but in the afternoons or nights following group therapy or psychodrama, there has always been some disruptive incident, such as the breaking of furniture, the absconding of one or two patients, a fight, or an insubordinate testing of the staff. This degree of acting out has been rare on days when there was no group therapy.

Now none of this behavior can yet be considered scientifically measured nor conclusively understood, but it does seem to point in the same direction as some of the other work we have done quite independently of this. It is as if we dealt with two types of thinking and behavior when we face human beings, and while some human beings are predominantly of one type, it is pretty certain that both types exist to some degree in everyone.

The first type of person looks at the world in an objective, "scientific" way. He detaches himself from what he observes and collects data about it. He "analyzes" this data over a period of time. He maintains, thus, a rather long delay between his perceptions and his final, decisive response to them. Classically this delay between perceptions and the definitive response is said to allow for rational thinking. Typically, if this sort of person gets too wound up or involved in what he is trying to analyze or to work out, he calls in a consultant who has a more detached, uninvolved and objective attitude than the first person.

Now a second ideal type of person is quick-tempered, impulsive, warmhearted or hotheaded, very closely committed and involved in what he is doing. He often puts his hands on people he talks to. He not

infrequently sticks knives in his friends. He is more interested in getting something practical done now rather than to plan at length for the future. He is likely to be a musician, actor, or politician rather than a scientist, teacher or writer.

Have we, as staff, been deluding ourselves into thinking that these soldiers must be judged in accord with our own middle-class objective, scientific ways of thinking and behaving? Must we ignore these other skills they show and the payoffs they get for their behavior? If a delinquent stag somehow forces a high-prestige stag into a fight, and both stags break up their antlers, does that mean that the high-prestige stag was stupid? Are we the delinquents who are forcing these soldiers to abandon the kind of swagger which they have developed in accordance with the rewards and punishments they got over the years?

II. The Psychiatric Ward as an Internal Political Power Structure

Dr. Julius Paul, our political scientist, has inserted himself into Ward 108 for a part of every day, in order to get a feel for the sort of unwritten constitution that the ward seems to be operating under. He looks at the formal and informal power structures and sees how the power values change around among the ward members from day to day, how deals and transactions are managed by the community. Acting homeostatically (usually) within the ward and acting as a vector upon the total hospital power structure, rules somehow are born. How are they employed and how do they finally die? Many psychiatrists are not interested in the political science aspects of their wards, until they discover that a certain patient has been incontinent for several months simply because within his peer group of patients he did not have bathroom privileges. He does very well when transferred to another ward.

Now since Ward 108 communicates closely when the posts to which its soldiers are finally assigned, and since staff members are frequently visiting near-by posts, we hope that Julius will be able to take his ideas about the development of rules and informal constitutions out of the pilot project of Ward 108 and eventually explore the ways that the mental hygiene service fits into the structure of the military post or perhaps the way that important local rules become established, utilized and eventually laid to their graves on a military post.

Julius has also been working on the problem of equity in the application of rules and regulations. He has tried to consider the manner in which a soldier becomes a candidate for a certain type of administrative discharge. What are the forces for and against a soldier who is selected for a certain discharge process? What does the soldier (or others) do to get a certain label set upon him in the process? To what extent can we have a universal juridical template that fits men without discriminating their positions in a local group. To what extent do local communities or even small groups determine the labels which are set upon certain members? Julius' work has been concerned mostly with the legal side of these questions. We can now turn to Col Bernard Wiest for some of the social and interpersonal considerations.

III. The Labeling of Men on Duty

Bernie Wiest has been interested in the past few months in whether men on duty become labeled by their own social groups in such a way that the label effects some change in their relations or behavior. Bernie narrowed his concern down to the primary group--that is, a group of people who frequently communicated with each other, face to face. Such a group could be a formally constituted one, such as a squad or team, or it could be a social group which cut across formal lines. Bernie assumed that the primary group was a discrete, social organization, within a military unit, and that these primary groups made certain rules and had certain effects of their own. The question then was--did the primary group effectively label a person, or did it require a commander or other empowered leader to affix an effective label? Do primary groups somehow decide to make some assertion to another group and then effect a communication by labeling one of its own members as a sort of ambassador or scapegoat to carry the message? For instance, does the group subtly encourage one of its members to go on sick call with some complaint which actually means "it is very difficult to live the way we are being forced to live in this group?" Does a primary group set up this sort of thing, or do individuals or do entire military units put pressure upon the most appropriate individuals.

How was Bernie going to investigate this problem? Should he go to Ft. Meade and interview soldiers who came on sick call? If he did that, he would probably find that everyone who came had a "rational" explanation for coming. The boy who cut his wrists had always been a little depressed off and on. The boy with a backache strained his back a year ago and has always had a little complaint now and then. When the case is seen from the individual point of view in a hospital setting, it is very difficult to see any group forces at work.

To overcome this sort of bias, Bernie investigated the daily working and social behavior of average people in three different units at Ft. Meade, Maryland. He selected a stockade, a trucking transportation company, and an artillery unit. Into each company Bernie sent one social work technician to live throughout most of the working day, and sometimes in off-duty hours. Every couple of days, the three technicians would meet with Bernie and pool their information. One method of delineating the primary groups was to give a questionnaire to the members of a unit. Typical questions were "name the persons you lend your car to." "Who do you lend money to?" No subterfuge was made; the technicians merely lived with the men and helped them do their work after explaining that they were researchers.

Now these technicians observed a lot of very earthy living. The verbal descriptions and the flow of everyday speech among the workers of the unit was far more picturesque than the best speech heard around the

laboratories at WRAIR. Some of the idiosyncratic behavior of the small groups was perhaps known by the commanders but was not formally recognized. In lieu of MPs, for instance, there were certain groups of unit guards sent from working units to guard prisoners in the stockade. These guards would sometimes march a very stiffly, obedient group of prisoners out of the stockade to their work areas, but as soon as they were out of sight of authority, the prisoners broke into a shambling gait, bummed cigarettes off the guards while the guards lowered their weapons and chatted along with the prisoners. Nevertheless, they performed their work satisfactorily. It is easy to see that certain minor labels and roles shift around from time to time, while some of the more spectacular and permanent labels may be crippling to an individual.

Bernie has finished his observations, but his work is still being digested by the computers. I wonder whether direct observation delineated the same primary groups as the questionnaires picked up. I wonder if there is a glossary of labels available to a unit.

IV. Mental Hygiene Consultation Practices

My own project was to explore over the past year or so about eight MHCDs--Mental Hygiene Consultation Divisions--in the Eastern part of the United States. I have been surveying what their operations were--the flow of work and the way the staffs handle the military community's needs. I interviewed certain key agencies on the post (health nurse, ACS, school principals, training officers, and key commanders) in order to see what they expected of MHCD and how much contact they had with it. Within the MHCD I examined the records and watched the clerks handle the flow of work and appointments. I followed officers and technicians around as they visited various units and institutions on the post. If they didn't go out to units, I would observe them at work with individuals, groups and staff in the clinic situation.

A few MHCDs were concerned enough about units to keep separate records for particular units. All MHCDs, of course, kept separate records on individual patients. In general, officers, especially psychiatrists, did not like to get away from the clinic, although there were some notable exceptions. Enlisted men worked most frequently in the unit areas. Generally, the early contacts with a unit were made around problems which were seen as arising over individuals. When the MHCD had worked together a long time with the unit, everyone more frequently saw the problem as a group or a unit problem and tried to affect the behavior and attitude of the group and not merely to reform or get rid of an individual.

There seemed to be two kinds of consultation in evidence:

(1) The consultant would get the consultee to utilize his own resources, while the consultant looked at the problem objectively.

and aloofly, as if he were an expert or indeed a small god. The very fact that the consultant was seen as an expert seemed to give him more practical power than if he were ever so wise but had not been considered so. In this kind of consultation the unit and its caretakers learned a great deal and improved on their ability to handle their own responsibilities. The MHCD did not take responsibility nor credit for solving the unit problem.

(2) The consultant intervened by getting close to the problem and to the people responsible for the work. The consultant felt some of the same sweat the various men of the unit felt for the problem. He stuck with the unit while it struggled through at least part of the problem. In this second type of consultation, the commander was often seen as wiser and more skillful in most aspects of human relations than was the consultant. The commander held the consultant to account for the sort of help obtained. The consultant could never say "here is my hour with you--take it or leave it." The technicians and officers found doing this type of consultation seemed to be in some measure that type of person that I have described as warm, closely-involved, emotional, sometimes impulsive, action-oriented. This is in contrast to the verbal-oriented, aloof, reflective, cool and scientifically detached consultant who was typical of the first type.

This second type of consultation is probably nothing new but is not the classically accepted way to improve a consultee's ability to handle his own responsibilities. The industrial and military worlds are changing, however, and this type of consultation may have an important place.

In this research project then, the questions are: How does the MHCD handle its relations with other services and units on the post so as to make work more effective and mental health better? How is the process of consultation with units and individuals carried out? What are the principles employed in handling certain special problems that face MHCD, such as (1) too many referrals to MHCD, (2) too many prisoners in the stockade with little rehabilitation, (3) too many soldiers on sick call, (4) high rates of accidents, delinquency, alcoholism, etc.

The personnel of the MHCDs seem to want the answers to these questions in the form of cookbook procedures or minutely described, illustrative cases.

V. Study of Deficiencies in Higher CNS Functions

CPT Peter Rosenberger is using some operant conditioning techniques to examine some of the problems of matching auditory with visual information and response. For instance, here is the case of a 14-year-old boy with a left middle cerebral artery lesion, who is accordingly unable to talk. Pete constructed an apparatus which presented several pictures or letters to view. The picture chosen could be registered on the recording machine by the patient's simply touching the figure itself, to indicate his choice. Auditory sample and visual choice were matched by speaking the name of a letter in the patient's ear, whereupon the patient would touch the corresponding

letter on the screen in front of him. Thus, if the patient heard the letter "A" he would select an "A" from among several other letters on the screen in front of him. Visual-to-visual matching was accomplished by projecting an "A" in the middle of the screen and then having the patient select the corresponding letter from among several on the periphery of the screen.

In this case, Pete found that the patient was virtually unable to pick out the proper pictured letter when he heard that letter pronounced, but, surprisingly, the patient had very little difficulty in matching simple words with their spoken names. Thus, if the word "dog" was pronounced, the patient could pick out the written word "dog" from among other simple words. He could also pick out a picture of a dog, as might be expected. Perhaps an explanation for this phenomenon is that non-verbal memories can be called to help in matching the written word "dog" with the spoken word, but a letter is such an abstract symbol and can be fitted into so many words that there are very few non-verbal associations to a single letter. One does not fear it, or smell it, or play with it.

The first slide shows the number of errors in twenty trials that the patient made when he was presented with spoken or written letters, and attempted to pick out that letter on the screen. He had virtually no errors in matching letters he saw to other letters he saw, but there were a great many errors when the patient attempted to pick on the screen a letter corresponding to a letter he heard pronounced.

Slide two shows the number of errors out of twenty trials of matching a particular heard word with a seen word. Notice that there are only one or two errors in matching words which represent picturable nouns, such as dog or book. There are more errors, however, in matching non-picturable nouns, such as song or trip. When even a picturable noun is spelled out, however, the patient cannot pick out the written word. For instance, if d-o-g is spelled out to him, he cannot pick out the word "dog" on the screen. There were other results when spoken or spelled words were pronounced and the patient tried to select pictures to represent them.

Perhaps it would help, then, after a brain lesion, to have the patient re-learn his verbal information in non-verbal terms--perhaps urging him to make special use of the non-verbal information he already has. Perhaps this is what patients do on their own, to some extent, anyway.

Pete and I were wondering the other day about the learning and retention of a true written language, such as Chinese. Europeans have never developed a true written language, but only a transliteration of a spoken language. The alphabet enables us to take an auditory language we already know and to record it on paper. If tape recording had been invented before the alphabet, there probably would never have been an alphabet. In classical Chinese, however, one written ideograph relates to another ideograph

without concern for the sound. Furthermore, in their calligraphy the Chinese play around more with an ideograph than we do with spelling or typography. Does the ideograph pick up more non-verbal associations? I wonder if the ideograph would be handled a little more as our patients handle pictures. Since it is not spelled out anyway, one either knows what the ideograph means or he doesn't know.

Now another thing touches me about Pete's work. As I have said, a lot of our consultation or our group therapy is concerned with intellectual insight, or the development of verbal ideas. We seem to handle these ideas objectively and aloofly. On the other hand, much change that is wrought within us and much persuasion that goes on between people is accomplished by non-verbal means--almost by a sort of tactile or visceral communication at times. We have seen this in our treatment of the soldiers on Ward 108 and we have seen it in Bernie Wiest's work with the behavior of soldiers in the field, as well as in some of the consultative relations among the workers of MHCDs and their consultees. I wonder if Pete's work here can show us some of the things that happen in the movement of visceral and non-verbal ideas or feelings across into verbal, symbolic and logical organization. How much of this problem is due to CNS connections and how much is inherent in the very geometry of the ideation within a social group?

VI. Semantic Analysis of Delusional Concepts from Psychiatric Interviews

CPT Herb Gross selected certain important words from psychiatric interviews with patients and had each patient delineate their meaning of these words on a scale called a semantic differential. For instance, Herb would take a word such as "president" from the patient's own interview and ask the patient to evaluate that word as to its maleness or femaleness along a five point scale. In this case, president would probably be in the fifth position of the scale, far over on the male side. Then the patient would evaluate it as to its hardness or softness. Perhaps president to him was neither hard nor soft, so he would put it in the middle position. He would do the same with such qualities as cruel-kind, curved-straight, and so on, for twenty different sets of qualities. This enabled Herb to plot each word along this scale of twenty dimensions, so that it came out with a wiggly line--a profile characteristic of such a word as president. Now Herb found that different words sometimes had about the same profile. In this patient's mind the word "guard" coincided thus with "president."

Herb also found that the meaning profile of a word tended to change with later testings on the semantic differential scale. The meaning of a word usually got somewhat better and more pleasant with the passage of days and weeks. Herb also found that "good" words, with more pleasant meanings, tended to have somewhat similar profiles, so that when these words were plotted on a multi-dimensional graph, the "good" words clustered in groups,

whereas the "bad" words would tend to have profiles unique to themselves and on a multi-dimensional diagram would appear as isolates, distant from even other "bad" words. The patient seemed to have more ways of describing the niceties of things than he had of describing the nastiness.

Some of the thoughts that have come to my mind with Herb's research were that perhaps the change in the meaning of words depends on the developing relationship between the patient, his therapist and the rest of his environment. Does the meaning, then, of any act or gesture in a long-lived consultation relationship depend on the stage of the developing consultant-consultee relationship--or upon the parallel development of the MHCD-unit relationship? Does the meaning of the gestures and the words generally ameliorate? It seems possible that during any particular human encounter the participants accept or reject the traditional word meanings and then proceed to modify those meanings with time and within that encounter. Thus, in the life we live at WRAIR, we put special WRAIR meanings on certain words. Since each of us has so much of his life involved in the world outside WRAIR, there are not a great many of these altered meanings. In the more intense team relationships found in combat, there is perhaps more change in meaning. I suppose that if a group lived on a desert island for a couple of centuries, the English they spoke in the end would correspond poorly with the English spoken on the mainland.

VII. Human Relations in Southeast Asia

I have always felt bad that we who remain in the stylish centers like the U.S. or Europe or Japan do not communicate well with those of us who go to Korea or Vietnam. When I left Japan and went to Korea, I found that my buddies in Japan would not answer my letters, and I got the impression that this was because they felt a little guilty for not going to Korea themselves, as if indeed they remained behind in heaven while I went to the hell of Korea--though I thought Korea very interesting. It seemed too, that people who returned from these unpopular places were not allowed to talk very much about their experiences. After all, if Peter Bourne comes back from Vietnam and talks to us of his experiences which we ourselves cannot really appreciate, and talks indeed in a GI language which is a bit peculiar to Southeast Asia, then we begin to get bored. Peter soon feels constrained to speak only in our language and only about the things that interest us in our little world here. Though I have deplored this, I have heard from people that worked at WRAIR before me that this dissociation of experiences and thought among the various departments here and the various localities where we go to work overseas--this dissociation improves the work that WRAIR produces. If we remained in constant communication with each other, we would tend to think as one mind. The people in one department would be unable to think very much differently from those in another department, even having an idea battle with them would still mean they were involved in the same thinking business. And so these philosophers of old have considered that the ideas and the work

of the various parts of WRAIR were mostly poured into the great central memory core of Dave Rioch and Joe Brady--and perhaps to a much lesser extent the department chiefs. It was thought that the memory core digested the ideas, fed some of them back to the departments, and eventually they were published.

During the past year, in Vietnam, Peter Bourne carried out several studies. I will mention some of them here. First, he wrote an article comparing the rate of psychiatric casualties in the U.S. Army with the rate in the Army of South Vietnam. He knew personally all the Vietnamese psychiatrists who were working with troops. In general, he found that the psychiatric casualty rate was remarkably low in both Armies, though it increased with increasing stress of combat. The number of psychoses was similar in both Armies. Among the Vietnam soldiers, however, there was a large number of neurotic diagnoses, especially with regard to somaticized anxiety and somatic symptoms of emotional origin which came after hospitalization for organic lesions. Among U.S. troops there were particularly high rates of character and behavior disorders. One might assume that the same conditions which produced neuroses--or at least the diagnosis--in Vietnam troops, produced the symptoms of character and behavior disorders in American troops.

Peter also made a survey of the total mental health activity in South Vietnam--in effect, examining the effectiveness of their "state hospital system."

Another study was the response of 17-OH cortico-steroid levels to the stress of the work among helicopter ambulance personnel. The helicopter ambulances evacuate the wounded directly and immediately off of the active battlefields. Peter thought there might be a difference in the anxiety of the men on days when they flew, as compared with days when they rested from their work. As parameters he used the 17-OH cortico-steroid levels in the urine, daily psychological tests, flying time in combat, hours of sleep, weather conditions. In general, he found that combat had no special effect on the steroids except that they tended to be lower than normal. He made some interesting observations on the minor sort of delusions the men used to defend themselves against anxiety.

Using his own motorcycle, Peter got around an awful lot in Vietnam. He certainly did not stay in a clinic or laboratory. At one time he lived with a Special Forces "A" Team which expected to be overwhelmed in a few days by a much larger enemy force. All this time, Peter collected 24-hour urine samples from every member of the team. It seemed that there was about as much research discipline shown as there was combat discipline. One interesting finding from this study was that the chronic mean steroid level for the officers was significantly higher than that

for enlisted men. This was interpreted as indicating that although the threat of death was equal for all men in the camp, the responsibility and social demands which cannot be so easily defended against as can the threat of death, produced a higher level of physiological stress in the officer group.

CPT Dick Morrill has just returned from a year in Thailand where he did studies in cross-cultural communication.

First, for teacher-student relations he observed members of the University of Illinois Medical Faculty at their teaching. In the medical school at Chieng Mai Dick observed the Thai students on ward rounds with their American teachers--considering how much the students talked, the attitudes they maintained, etc., and compared this with similar observations when the students were with their own native teachers. He went through the usual controls--testing their ability in English, for example. Naturally a student would not talk as much to an American if he didn't know English pretty well. He took into account the student's ambitions, their ethnic and family backgrounds, expectations, attitudes toward education and innovation. Dick was especially concerned with the amount of self-initiated verbal activity, since self-initiated talk by a student to a teacher runs against the grain of normal Thai tradition.

This work is still in the raw data stage, but it would appear that it measures some historical changes in the practice of our disciplines right where the professional relations are cooking--in the crucible of Thai-American personal interactions.

In summary:

(1) The character and behavior problem ward is giving us untraditional ideas about the relation of expressed inner feelings or plans with the actual behavior of patients and staff.

(2) This ward seen as a small community is revealing its informal power structure and its process of establishing an unspoken "constitution."

(3) The study of labeling men by primary groups, units or authorities reveals a sort of human interaction among peers which is quite different from what the peers will say in the doctor's office.

(4) Mental hygiene practices include not only the traditional aloofly objective consultation but also some interaction between consultant and unit which look like tribal or extended family acceptances.

(5) Damaged CNS functions seem to retain better the ability to associate percepts across sensory modalities if the percept has many gutty non-verbal connotations.

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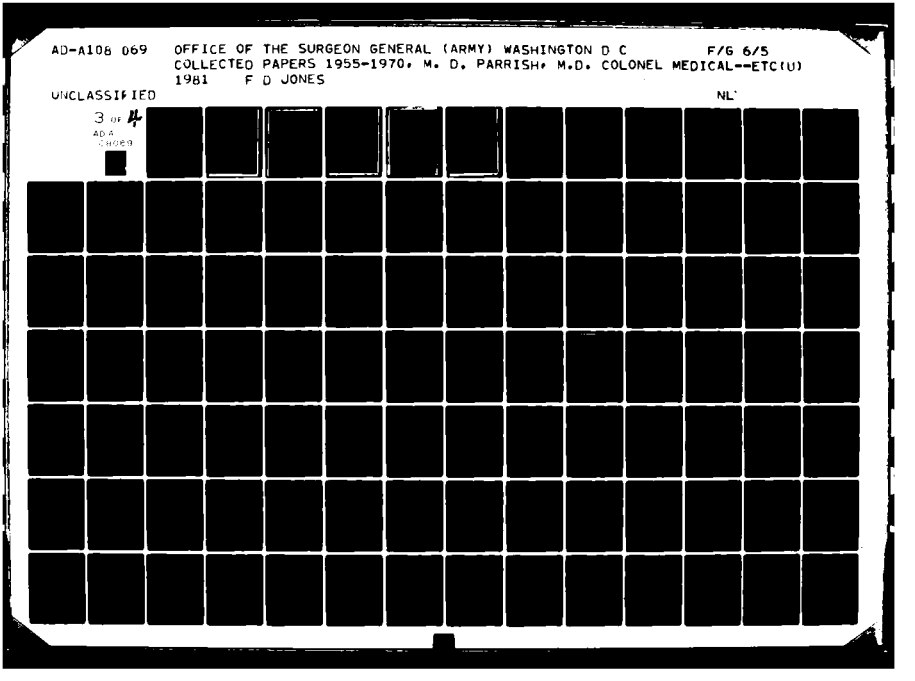

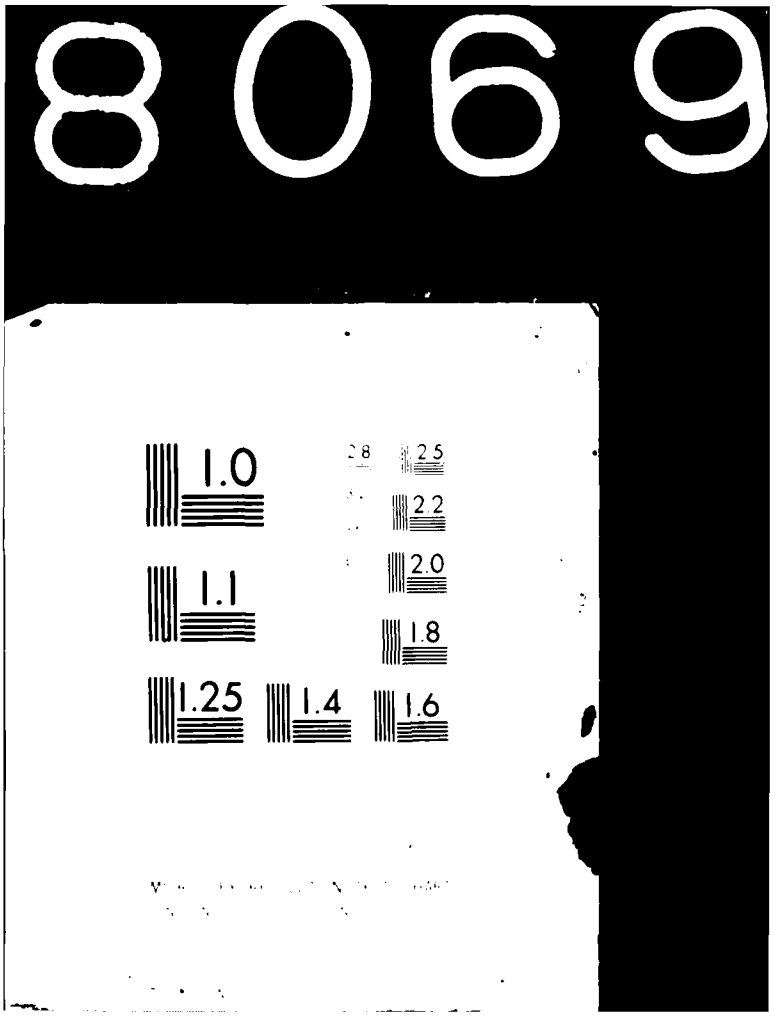
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(6) After the development of a means for profiling and correlating the idiosyncratic meanings of various delusional concepts, it was found that the correlative meanings of such concepts became more pleasant with time.

(7) The sorts of casualties and the effects of certain social and combat stresses in Vietnam were studied.

(8) The peculiarities of certain Thai-American face-to-face relations were explored.

#34

(32)

MHCD Morale - Key to effective community mental health work

This paper sets forth the author's observations on morale (1964-1967) at some 30 military psychiatric facilities both in the U.S.A. and overseas.

MATTHEW D. PARRISH, LTC, MC

On certain posts there is among qualified EM a scramble to be assigned to the Mental Hygiene Consultation Division. Their assumption is that the staff of MHCD:

(1) Deals with more interesting problems.

(2) Has more fun doing that work.

(3) Brings out better cooperation among staff members.

(4) Affords more useful education to staff EM.

Where this attitude does prevail, the MHCD is usually more resourceful, more efficient and more broadly extended in its work. Where this attitude of cooperation, or learning and/or work is lacking on the other hand, the staff member often works only because he has to. He hurries through his 8-hour day in order to do "more important things" in civilian life. He hurriedly "wastes" his years of military service in order to do "more important things in civilian life" - not realizing that military training in depth can promote him into far better civilian work than he otherwise could have managed.

This paper assumes the clear understanding that the paramount importance of consultation with community leaders and of examining problems in the actual work situations where they arose, and the careful supervision of all treatment and consultation. It will point out some parallel activities among MHCD members which lead to high morale, but which have never all been found at the same time in any one MHCD, although all of them have actually been practiced in professionally efficient and creative MHCDs. The comments on MHCD apply also the psychiatric operations in combat divisions, and in the overseas hospitals which carry on programs of stockade, school, command consultation, etc.

What are some of these activities found in high morale MHCDs?

I. Continued Contact With Former Staff

(a) The secretary keeps an up-to-date list of addresses and employment situations of all former members of the MHCD. Since this makes present members feel that they too will be remembered, they try to make their work bear a useful influence on the future.

(b) Former staff are welcomed as visitors and are often in a position to help with civilian jobs, schooling, and "political" information. They help the actual MHCD work to keep up with general professional growth.

(c) Former members who work in local schools, courts, social agencies, governments, etc., are especially helpful. Usually local governmental agencies are quite glad to hire men with MHCD training. This is especially so when the agencies have worked closely with an MHCD.

II. Education and Training: Training in an MHCD is usually given with a view to the world-wide needs of MHCDs, and indeed with an eye on the usefulness of the training in modern community mental health work, and all the related fields it overlaps - e.g., trans-cultural relations in developing countries, trans-social-class relations, management and leadership of enterprises, general systems theory, Special Forces work, organizational research, teaching methods, operant conditioning in a social setting...

But these things are best learned by constant reference to the case and organizational material that comes up in the daily work of the MHCD. This work has far more interest and meaning if seen in relation to two or three theoretical models, such as social psychological, psychoanalytic, cultural, general systems, political science, management theory. MHCD officers have a lot to teach the technician and also a lot to learn from him, particularly in the course of community consultation where technicians are feeling out the informal sociometry within an organization (unit, school or home...) while the officer deals with the formal structure and with the social echelons above the specific organization. Some formal methods of teaching are:

(a) On the Job Training - Including supervision of the technician who is seeing patients and organizations in the working area of the organization itself.

(b) "Journal Club" - One or two significant journals are signed to a pair of members to be evaluated and reported upon when significant articles appear.

(c) Reprints - These are requested from authors by personal letter from the technician. Occasionally by writing an appropriate letter, a technician has begun a long and useful friendship with the auth .

(d) Speakers - Usually non-paid volunteers speak on the work of alcoholics anonymous, missionary experience in South East Asia, community mental health work in an adjoining country, rehabilitation of delinquents in a model reform school, theory of teaching how MHCD looks to the guest psychiatrists from a class-two hospital. Sometimes these speakers are ex-members of the MHCD.

(e) Teaching Seminars - On a particular subject, current and classical reading is assigned - e.g., Subject: rural versus urban social needs and attitudes. Classical material: (1) Tonnies on Gemeinschaft and Gesellschaft. (2) A cultural anthropology text. (3) Spengler on "the soul of the city", (4) Mumford on "the influence of architecture upon society", or, Subject: consultation techniques. Classical material: Ranges of consultation thought from Plato's Theatetus to Caplan's Principles of Preventive Psychiatry.

(f) Field visits to other institutions by individuals or groups, who report back to MHCD in plenary session. Visitors sometimes live-in at the outside institution for some time, on pass or leave: (1) Special hospitals - mental, alcoholic, childrens, therapeutic community, foreign hospitals when available, such as South American, Korean, German, Viet Nam. (2) Prisons, jails, reform schools, e.g., National Training School for Boys. (3) Social work agencies. (4) Schools: elementary, high school, special (Edgemeade, Boys Town, Devereux, military schools), institutes for the deaf, etc. (5) Community offices: governing boards, courts, public health, police, even libraries are visited and understood as a part of the communities' energetic drive towards better education and development of children and parents, physically and morally.

(g) Regional MHCD Conferences: These are planned and carried out by the MHCDs themselves, and usually include papers and discussion by both EM and officers of all disciplines, thus all MHCDs in an Army area may send members to a conference at a centralized MHCD.

(h) Letters to and from the staffs of other MHCDs: These are not merely official letters between chiefs, but informal letters between NCOs or technicians - often stimulated by the passing visit of some member.

(i) Specific studies that help technicians prepare for their military and/or civilian future: (1) USAFI and other correspondent courses. (2) MHCD helps the technician to contact institutions which might employ him and where also he might be influential concerning Army and community psychiatry. (3) Night school. (4) "Moonlight" work in institutions most useful to MHCD, e.g., as group therapy consultant or worker in a civilian clinic which handles many service families.

(j) Social visits by technicians in the home of a good line NCO in order to see the depth of his point of view and the way it fits into a normal NCO life.

(k) Language projects: (easy because in a foreign country MHCD has such ready access to native speakers).

(l) Learning in interaction groups: German and Japanese has been learned in an unstructured type of group interaction similar to group therapy. A native speaker at the elbow of each American tells him what to say in response to each emotional transaction. Thus, the foreign language is learned by direct response in that language to the perceived social situation, and not by encoding English responses into the other language.

(2) Teaching in social groups: English was taught to Korean teenagers on weekends in the clinic building. It was also taught by small groups of MHCD members in the homes of the Prime Minister, certain mayors, newspaper editors, etc. Teaching upper class people squelches most objections from the stay-in-the-compound Americans.

(3) Interview practice: A member who knows Spanish well, supervises an interview between a Spanish patient and a student member.

III. Recreation

(a) Travel:

(1) In Europe, clinic members have taken to riding bicycles not only to work but on long international travels. Old members break in new members on the fine points of cycling over Alpine passes. The self sufficient camp equipment is usually more complete and far lighter than anything QM issues.

(2) The clinic keeps a map showing the routes taken by each member, so that a new member planning a trip can quiz the appropriate travelers.

(b) Music ensemble with rented or checked-out instruments.

(c) *Picnic: Often in combination with for example, some engineer* unit which has a boat.

(d) Home brew parties.

(e) Flowers and plants grown inside the building; MHCD garden outside.

(f) Great Books discussions (sometimes natives are invited).

IV. Creative Projects

(a) A case is written up for publication or for informal local consideration (practice in creative thinking, writing).

(b) By group seminar, new treatment and consultation techniques are devised -- also new clerical procedure.

(c) Seminars in cross-disciplinary thought - Members combine with business administrators, librarians, teachers, electronic engineers, musicians or mathematicians, to discuss "information theory" or "teaching technique."

V. Developing a Public Image

(a) One or two members of MHCD usually make friends with a couple of journalists and easily get articles on MHCD into post and civilian papers (after clearance with the Public Information Officer).

(b) Some MHCD work is presented at the hospital staff meetings. These are among the most interesting hospital conferences because they're so different from the usual run of presentations.

(c) MHCD work is presented at local medical society.

VI. Influence With Patients: The increased morale and the interaction of the MHCD with the community is inevitably felt by the patients. The professional enthusiasm and the orientation toward work and the real world is contagious. Because MHCD feels no barrier between itself and the community - (members walk, drive and cycle, exploring through units, societies, languages) - it also feels no abnormal barrier between staff and patients and consultees. Once these "high morale" MHCD activities are developed, many of them can be drawn upon to benefit patients.

(a) Out-patients and staff may sit together to plan clinic services.

(b) Line NCOs, officers and members plan clinic services.

(c) Patients in waiting room are arranged in clusters so that they can interact with each other under the eye of the receptionist. Patients thus receptive to each other, ease their own introduction to treatment and to coping with their real worlds. Some patients care for the clinic's plants and garden. They get cokes, may bring food for groups etc.

(d) High morale clinics find it much easier to develop and carry out complex procedures such as multiple impact therapy of units or families, marathon group therapy, double group therapy, orchestrated leadership conferences.

THE COMMUNITY MENTAL HEALTH CONSULTANT AND HIS EDUCATION

(Letter to the Associated Faculties of Psychiatry, Washington, D.C.)

COL. MATTHEW D. PARRISH, MC, JUNE 1967

In the Associated Faculties Seminar on Community Psychiatry (1965-1967) we explored many ideas about the education of the community mental health worker in general and the community psychiatrist in particular. I'll put together here my own version of these ideas. While my version was stimulated by the seminar, I don't maintain this is the proper consensus of the entire seminar.

ASSUMPTIONS:

1. The typical student comes to medical school with the desire to take care of individual patients, one at a time. He seeks appreciation from individuals whose lives or limbs he sees himself as saving.

2. In all his curriculum he most poorly tolerates public health.

3. While the public understands public health medicine, it is confused by the, as yet, vague concept of community mental health.

4. Students entering other professional schools such as Social Work, however will often have a high interest in social and public welfare concepts.

5. In his training and practice the social worker may easily change his work dedication to fit the needs of the institution where he currently works. Thus, he easily sees himself as a psychotherapist at one time and later as a welfare or community organization worker.

6. The social worker can easily picture himself as a person who does his part in helping the community as a whole take care of a problem. The physician usually sees himself as a sort of commander who takes over total responsibility in a special field. His clinic likes to take in a problem, work on it, and then discharge it back to the community without much continuous coordination between community and clinic upon the problem itself.

To alter the above tendencies in medical students and to make the graduate psychiatrist comfortable with community mental health practices, the following suggestions are offered:

1. A student should be admitted to medical school as a general rule only after he has developed the ability to make his way in the working world at some occupation. A group of physicians who today seem especially broadmined and who comfortably modify their professional identity with changing times are those men who served in the armed forces during World War II and then went through medical school on the GI Bill.

2. Medical school should concentrate more on the processes by which illness develops and on how to intervene in that process in such a way as to keep the individual functioning in his society. Currently, there seems to be too much emphasis in medical school upon removing illness as if it were something to be exorcised.

3. Medical school should concentrate more on the sickness of families and work groups rather than of individuals merely. Thus, food poisoning or peptic ulcer can be seen as a problem produced by a family or group as a problem

that is part of that family or group, rather than a problem that belongs solely to the individual showing those symptoms.

4. In all phases of a psychiatric residency there should be constant consideration of the community outside the hospital or clinic and the doctor's and patient's relationship to that community.

5. The usual three stages of a psychiatric residency could be taught something like this:

First stage: The resident learns to work with a group psyche model, an example of which I described in my first letter to the Senior Seminar of the Associated Faculties. When working with psychiatric in-patients, he should be able to see the effect of a single patient's therapy upon the patient-staff group of the ward as a whole. He should learn to deal with the powerful group forces of the ward which help a patient toward effectiveness or disability.

Second stage: Developmental psychology--this is probably taught best with a child psychiatry practice which includes, not only the child's own development, but the changing family and local society. Developmental also includes aging and death.

Third stage: Skill with both individuals and groups is combined in a managerial way--coordinating family, community, and clinic assets. Further, the resident learns to abet the development of programs, not individual treatments. He participates in the convening of support networks.

Since students (happily) come to their psychiatric training with widely varying backgrounds of education and experience, it is hardly appropriate for every individual to have exactly the same residency training. The faculty may even re-tailor his pre-residency education.

It can be seen that the above suggestions are an effort to avoid the pattern which requires one to be many years a student with gradually increasing specialization, followed immediately by institutional work in an extreme specialty, and then by practice in that same specialty. Such a specialized education produces a single adult identification. Interim marriage, a new hobby, or religion may extend this identification but cannot change it fundamentally. The individual still thinks with the same grammar, the same mores, and maintains the same tastes with regard to his work.

Now let me overemphasize a bit to make clear the contrast, as I see it, between the education of the community psychiatrist and that of the traditional psychiatrist.

1. For a community psychiatrist select a <u>country</u> high school graduate (for he can learn city ways while a city boy can seldom breast the style gradient vigorously enough to learn the country feelings).

2. After some cultural orientation send him to work 6 or 12 months in Asia or South America to a village where no English is spoken.

3. Put him back in school to learn the sciences and humanities (the "two cultures").

4. Put him in military service for a couple of years letting him commit himself to the group and to the roles he practices within it.

5. Send him to graduate school (medical school if he is to be an M.D.) making sure that some of his training is in anthropology, business administration, and political science.

6. Let him take his "residency training" with a preceptor-institution doing community mental health. Didactic work should bring him fair understanding and control of his internal assets and difficulties as well as his manner of managing his natural group life. Effective in many instances would be personal psychoanalytic exploration as well as a group exploration of his manner in a natural group. At this point he should, so to speak, obtain his license.

7. To qualify for his Boards, he should go on to: (1) spend a couple of years consulting in at least two different communities, (2) hold elective political office for a couple of years.

It is hoped that this plan of training suggests the radically different area needed for those who work with broader psychic realms than that of the individual.

8/25/76

MENTAL HYGIENE CONSULTATION DIVISION

SECTION IV

By M. D. Parrish

Extended management of individuals, families, dependents

20. Usual course of psychiatric intervention

This section discusses an extended range of management considerations with special reference to certain dramatically presented dependent problems. The same principles apply to management of single or married soldiers and to very brief, as well as, prolonged interventions.

Effective therapy is most often brief. It uses a crisis to link the patient responsibly and helpfully with his own social system (his family or unit) then it links the family with a wider society (preferably with neighbors or fellow workers). When, occasionally, a family has to link temporarily with a social agency such as welfare, consultants should guide the agency to get the family included with some "extended family" or neighborhood action where the patient can become an important and productive member.

21. General principles concerning dependent problems

Many proud military men, when told their symptoms are without organic basis, will avoid further complaint. The causative stress from unit, family, or economic situation, however, leads them to express their difficulties within the family. The family members may then absorb excessive stress. As a consequence, a dependent appears at the Medical Clinic with a non-organic symptom. The military society far more easily condones "chronic sick call" for a dependent than for an experienced soldier. "Supportive" medical or psychiatric treatment for this dependent may alter the family equilibrium in such a way that treatment becomes interminable because it is now a part of the family's adjustment.

Since dependents are thus a part of the psychiatric epidemiology within a local military community, the Mental Hygiene Consultation Division keeps track of all psychiatric treatment of dependents. Having historical records, even from other stations and having frequent face-to-face contact with duty units, school, family and other groups, MHCD quickly grasps the social meaning of the patient's symptoms and uses the family or unit as a therapeutic milieu to prevent a neurosis from paying off at all. A hospital-imprisoned psychiatric out-patient service treating the dependent alone, however, would never be able, thus, to handle the total family or community problems.

Today's MCHDs, then, utilize the referrals of dependents as early indicators of human relations difficulties in the family, the unit, or the neighborhood. As a general rule, psychotherapy should not be instituted with a dependent unless it involves the sponsor also. Years of experience at many MHCDs have found that to give concurrent and equal psychiatric attention to the sponsor or to take him into total family interviews is to put the responsibility in the most effective channels.

Such management puts the entire family system on the road to recovery which can eventually be maintained without further medical intervention.

Except for an initial interview, individual psychotherapy is not resorted to until after counseling conferences with family, Command, neighborhood, school, or other appropriate groups. One-to-one therapy is a rarity since (1) it is less effective, (2) it deprives the rest of the community of psychiatric services, (3) because of his own needs an occasional psychiatrist gets so involved with patients that he doesn't see the point where non-psychiatrists can help more than he.

When dependents or families go to civilian psychiatric institutions under Medicare, CHAMPUS, or on their own, they recover more thoroughly and quickly if the MHCD works closely with the institution. Most local civilian agencies are very glad to work with military consultants.

22. Working assumptions

In outline below are certain working assumptions which if maintained will usually make for more comfort in the mental health workers, the dependents, and the community whenever problems are handled which were presented as symptoms of an individual.

These general principles apply to the soldiers and dependents handled directly under the supervision of MHCD, whether in hospital, clinic, or neighborhood setting. The principles also apply whenever MHCD acts as consultant on the far greater number of dependent problems handled by Army Community Services, Legal Aid, Red Cross, personnel sections, or civilian institutions.

a. A symptom is a communication.

(1) Thus, fear of heights developing in a wife who had to take a fourth floor apartment may be a communication to the Medical Corps that she wants to live on the ground floor like her best friend. (Or perhaps her husband is more irritated than she, but his complaint gets no attention.)

(2) A bleeding wrist from a wife's suicidal gesture may be a communication from wife to husband that she wants him to do certain things and it is at the same time a communication to the Medical Corps and thence to Command that something must be done to relieve her and her family. Sometimes the gesture is a communication from the sponsor's unit to the effect that "Work is so hard around here and and hours so long that some of our wives are even driven to suicide."

b. Anxiety is transferable.

Working definition of anxiety: a feeling of vague apprehension or restless discomfort as if the patient were restraining herself from experiencing a certain pure emotion

(such as anger toward her baby) and is left plagued by the free energy of that emotion. Avoidance of the appropriate emotion allows the patient to maintain her image of self as a person who is above having such an emotion.

(1) A student, apprehensive over an impending examination, may rid himself of anxiety by asking another student if he knows the answer to some complex question. If the second student then anxiously scurries through his books to find the answer for himself, the first student can smile happily: the anxiety has just been transferred.

(2) A paratrooper in training is afraid to jump. His platoonmates ridicule him, thus strengthing their own faltering courage but increasing anxiety in the trainee by rejecting him from the group, while restraining him from hating the group. The platoon anxiety may thus become condensed into this one failing trainee.

(3) An anxious soldier about to begin a combat mission may be reassured by other men who really are reassuring themselves. They see the first soldier as the one with anxiety--not themselves.

c. Symptoms are transferable.

(1) A wife, very angry and lonely that her husband is overseas, cannot at first sleep or eat well. She talks to her three year old son in such a way that he exaggerates and retains beyond the natural time his disturbance at father's absence. This child then soils the bed, loses weight, talks to himself a lot, but the wife now feels anxiety only about the child's symptoms.

(2) A soldier who feels great stress at work, but cannot there complain, may be so obnoxious to his wife and children that one of them develops a chronic headache or stomachache. Sometimes it is found that the sponsor had an ache until the other family member developed it.

d. Symptoms are transformable from one type of symptom to another within a single group or individual.

(1) Within a military unit the prevention of a high rate of unnecessary sick call may result in a high rate of AWOL. Prevention of AWOL may increase fights or thefts or accidents. In combat among troops with poor morale, a high malaria rate which is decreased by forcibly making the men take suppressive measures may result in a high rate of wounds of the foot. A student group which responds to what it thinks is unjust harassment by having its best scholar show up for class drunk may later respond to the same sort of problem by having one of its members attempt suicide or by the failure of all the brightest students.

(2) Within an individual, anxiety may be converted into overeating, which results in obesity. The obesity may in turn be transformed into excessive smoking. Headache may be transformed into agression, hypochondriasis into paranoia, insomnia into drug habituation.

e. The symptom which pays off socially the most is the one which becomes most permanent and prominent.

(1) If the local society is inordinately concerned over the mental health of children, and children get psychotherapy twice as easily as adults, then a family will have a strong tendency to shift its anxiety onto one of the children. The child can then have the anxiety drained off in clinic therapy and return to his family for a refill.

(2) If it is the current style for overworked wives to have migraine, then an individual wife will have less tendency toward frigidity, alcoholism, or "weak heart."

(3) If a husband overseas without his wife is unsympathetic to her phobias or headaches but is jealous of possible lovers, then the wife is not so likely to have headaches but may write to him saying that she must seek lovers for sexual relief unless he comes home right away. Occasionally such a wife appears at the MHCD with her sexual complaint.

(4) If fear of high places is considered locally a reason to move families to the ground floor apartment, then those families who hate to climb stairs will not be so likely to develop a member with headaches or fear of horses.

(5) A company experiencing a tiresome field maneuver may declare that a sick member had his breakdown precisely because of the stress. "It was enough to drive anyone out of his mind." The implication is: "I didn't break down though; look how tough I am and how much special consideration I should get for going through such stress." The company may itself have to develop symptoms which will get special attention. Stress may indeed be enough to evoke some symptom, but the symptom most likely to develop is the one which Command and the Medical Corps attends to most dramatically.

f. The symptom comes to rest most chronically in the member who can resolve the most group needs with that symptom.

(1) A wife can usually see a doctor much more frequently about a vague complaint than her husband can.

(2) The symptom of a wife or child will often effect a transfer, curtail a tour, or get quick housing. A husband's symptom may only get him a discharge or a less desirable job.

(3) A symptom in a child or wife may allow a family to avoid frightening sexual relations or chores, and may set up a new pattern of relationship which the family desires--though often with uncertainty and mixed feelings.

g. The patient and family and even the unit may act as if their aim were to maintain the sickness.

(1) Attempts to get people together who contribute positively or negatively to the illness may be met with great resistance. The unit or neighborhood may in effect say: "The clinic set itself up as a caretaker for emotional troubles. Now the clinic must treat exactly the persons we throw up to it and not try to change the rules of the game."

(2) The social system which maintains the illness will often integrate the caseworker or doctor into itself as an honored maintainer of interpersonal games. He may repeatedly skim off the cream of the anxiety so that the family system can continue to stagger along.

h. The dependent complains as a member of a family.

(1) The dependent's symptoms are usually a part of the emotional interaction of the sponsor's nuclear family with its environment, or a part of the strains among its own members--that is strains among father, mother and children. Occasionally though, the symptom comes out of the emotional system of the wife's or huband's parent family.

i. The family as a whole usually acts as a member of a larger group, such as: the sponsor's unit, the military housing area, the school, the church, or the local civilian community. Within the group, that family plays a role such as the happiest family, the poorest, most litigious, most generous, most physically sick, etc.

j. The family is the responsibility of the sponsor, and through him, the responsibility of his unit.

(1) The unit can often help MHCD with a problem family.

(2) MHCD can often help the unit with a problem family.

k. The most effective psychiatric evaluation and treatment of a dependent proceeds only in a family context involving the the sponsor and also involving any appropriate community groups.

(1) If we fail to consider the network of social and group emotions and activities around the dependent, we avoid the total problem system. Such avoidance is like examining only an aching back and not the shoe nor the work situation which may be causing it.

(2) MHCD does not live with the dependent and does not have as much everyday regulatory effect on her as does the sponsor or the local neighbors.

(3) If the sponsor is overseas, he obviously can't be present at treatment, but usually the dependent is involved with other individuals and groups which can be linked up to provide a solution to the problems.

l. Just as evaluation of the dependent and family may necessitate considering groups to which the dependent and family belong, so also may these groups be effective in the treatment of the problems.

(1) The most effective treatment usually utilizes husband and wife together and including any appropriate child. Other effective treatment procedures may be:

a. Conference of neighbors or stairwell members.

b. Clinical group therapy--mixed husbands, wives, and even children--or wives and husbands in separate groups.

c. Family conferences with teachers, military police, etc.

m. The particular attitude an individual manifests is apparent only in certain social contexts and cannot be maintained in other contexts.

(1) Frequently a patient who is the sickest on the hospital ward and is nursed by the others begins to function better and may take up a nursing role himself when an even sicker patient becomes a ward member.

(2) Certain dialect sounds and phrase patterns may seem irritatingly silly, prissy or doltish to an individual in one region: but if he then lives in the region where that dialect is proper to the society, he usually adopts that very manner and feels it as a natural part of his true self. The same applies to styles of management, treatment, training, or child rearing.

(3) When the total membership of a ward decides to maintain an attitude which changes the meaning of patient A's behavior, then A may no longer be able to maintain that behavior. Thus in a "ward community" meeting the staff and patients may decide to adopt a constant attitude of kind firmness toward a depressed patient in order to move him out of a depression. The group may assign him the task of sandpapering a board 10 hours a day while all the ward maintain a gentle but firm guidance upon the minute details of his manner of performance. After a time the patient can no longer maintain his old depression. What a patient is able to feel in this instance is determined by the social context in which his feelings occur.

n. A course of social behavior set up as a non-serious game played out quite knowingly by all members eventually has the same therapeutic or destructive mental effect as does "real behavior." This fact can be utilized in individual therapy and in social management.

(1) Bayonet practice, certain war games, and other such "unreal" training afford well known emotional conditioning for actual combat.

(2) Hazing or other games set up as innocent fun sometimes result in serious injury as certain people lose themselves in the game.

(3) Family or unit games such as sexual teasing between father and daughter or sports tournaments on a post have had strong emotional effects of pain, of relief, of social disintegration, and of group cohesion.

(4) Psychodrama or other role playing techniques carry patients through quite the same emotions that real experience does.

(5) Children (or adults) at play with toys or pets "dream out" or "act through" much emotional conflict. Depending on how the game is managed, feelings may be relieved or intensified.

(6) "Unreal" drama played on stage brings to the audience real tears and other emotional reactions.

(7) As illustrated in m. (3) above, a ward patient responds readily to the deliberately laid-on behavior of the total patient group in "attitude therapy," even though he knows it's all a game.

o. The patient must get practice at functioning in social and work situations--in play and in reality. For relief of deeply intrenched dysfunctions, intellectual and emotional insight is not enough.

(1) An interminable psychotherapy can, of course, support the patient indefinitely by making the doctor a supporting part of her pathological social relations. Patients who can eventually abandon long term one-to-one therapy usually do so because they have concurrently gotten practice (and eventually skill and confidence) with people and work outside the interview room. Improvement of character and psychic defense structure occurs largely by practicing (usually under some therapeutic guidance) until the social skills, friendships, hobbies, work projects, etc. are taught into the patient's muscles, bones, and sense organs. A pianist thus gets the skill into her fingers. She can't come to function as a pianist simply by a life of intellectual and emotional study in music literature and theory.

Practice which enables the patient to develop skill, confidence, and self-enjoyment with others is obtained, for example, in:

a. Occupational therapy--where the patient may have a succession of small successes, dealing first with the non-human environment and increasingly with the social and with complex resource-challenging tasks.

b. Group therapy and psychodrama--where the patient may manage emotionally certain trying social relations in an artificial atmosphere (see par. 22).

c. Sports or dancing--both social and as a performing art. The body gets the feel of social communication carried on physically.

d. Formal schooling--broad usage of the mind expands it.

e. Money-making jobs bring economic confidence, independence, and social tact.

p. The most effective general therapeutic technique is to make the patient a member of a group which works on a task external to the group.

(1) Small nations, by commercial or military aggression or defense, may thus get coherence and loyalty among citizens. Individuals come to live through hardships that otherwise would have brought many disabilities.

(2) Military units may thus integrate individuals with pathological characters. Individuals function in groups under extreme hardship, without decompensation.

(3) Similarly, individuals are improved in certain industrial work or in group therapy or community projects.

q. By publicizing a diagnosis a psychiatrist manipulates both patient and society. At the same time, he gives society a lever to manipulate the psychiatrist.

(1) A psychiatric diagnosis aimed at merely describing a patient may actually give him a new official identity. Diagnosis tends to deprive the patient of his community's acceptance of him and feeling of responsibility for him. He becomes estranged from the normal agencies of socialization and production. For the community usually reacts as if the psychiatrist had taken on alone the work of curing the individual, with little right to get help from other forces.

(2) Even in true mental diseas, the level of social functioning is more important than the diagnosis alone. Chronic

schizophrenics have run efficient businesses while hallucinating. Yet some passive dependents have been unable to dress themselves.

Experienced MHCDs often give the sort of diagnosis (or lack of it) which will lead to the most appropriate disposition. For example:

a. If long term therapy is desired for an interesting dependent, a neurosis is diagnosed.

b. If administrative separation from the service is most appropriate, a character and behavior diagnosis is made.

c. If hospitalization or medical evacuation is desired, a psychosis is diagnosed.

d. If a fairly quick and functional acceptance at duty or community life is desired, then all psychiatric diagnosis is avoided.

A diagnosis tends to strengthen the disability socially. Even unpublicized diagnosis if considered of major importance by the attending staff and discussed behind closed doors, causes the medical community to act toward the patient as if the diagnosis were published, and the same effect prevails.

r. <u>The most effective individual clinical treatment of dependents occurs when the therapist is being supervised by another therapist.</u>

(1) An attractive wife or child can often become so interesting to the therapist that long term individual or group therapy is instituted to continue the interesting relationship. Supervision minimizes this tendency.

(2) Disturbed patients sometimes take legal action against therapists. Professional supervision often saves the therapist from grief.

(3) Nurses, school counselors, pediatricians, occupational therapists and certain experienced volunteers, make very effective individual, group, and neighborhood counselors if given practical training and supervision.

(4) Thus any therapist is continuously a communicant in a professional group.

s. <u>Emergencies are, of course, treated as individuals, in spite of the social causes of the emergencies.</u>

(1) A knife wound is treated directly, even though its origin is traced to the interpersonal problem which caused the fight. The interpersonal problem is treated in coordination with other agencies such as Police, Clergy, and Command. Once the initial emergency period is over, the patient is treated as part of the family or community system.

(2) A suicidal gesture is handled individually but in such a way as to make further gestures less likely in this patient or in others. If the patient is not psychotic nor significantly depressed, good management usually returns the patient to work as soon as function is restored. A reconsultation with unit and/or family follows immediately.

23. Summary of Working Assumptions.

a. A symptom is a communication from an individual (patient) to an individual (medic) and always also from a group (family, unit, neighborhood...) to a group (medical profession).

b. Anxiety is transferable from one person or group to another.

c. Symptoms are transferable.

d. Symptoms are transformable from one symptom (overeating) to another (excessive smoking).

e. The symptom with the greatest payoff to the surrounding society is the one which becomes most permanent and prominent.

f. The symptom comes to rest most chronically in the member who can resolve the most group needs with that symptom.

g. Patient, family, unit, may act as if to maintain the illness.

h. The dependent complains as a member of some family.

i. That family plays a role as a member of a larger social or working group.

j. The family is the responsibility of the sponsor, and through him it is the responsibility of his unit.

k. The most effective evaluation and treatment of a dependent closely involves sponsor and appropriate community group.

l. Natural unit and neighborhood groups can often provide the most effective treatment or rehabilitation.

m. A member's particular attitude or symptom is manifested only in certain social contexts.

n. Games have the same therapeutic or destructive effect as "real" behavior.

o. Intellectual and emotional insight is not enough. The member must get practice at functioning in social and work situations.

p. Most effective therapy makes the patient a member of a group which devotes energy to a task external to the group.

q. The psychiatrist uses diagnosis as a lever to manipulate the patient and his society. But they in turn use that diagnosis to manipulate the psychiatrist.

r. Individual clinical treatment is most effective when the therapist is himself under supervision by a peer.

s. Emergencies may be temporarily managed as if individual problems, but are soon linked to their social origins.

#37

7/26/74

INFORMAL PRINCIPLES UNDERLYING MANAGEMENT OF MENTAL HYGIENE PROBLEMS

By COL MATTHEW D. PARRISH, MC USA Ret.*

I. Sources of Data

During two years of on-site research exploring the work of nine Eastern U.S. Army Mental Hygiene Consultation Divisions (MHCD), the author concluded that several useful and efficient MHCDs functioned as if they were following certain unstated postulates and principles when they handled the problems of military units, schools, soldiers, and families. Some members of these MHCDs would openly avow among colleagues certain of these principles as fundamental assumptions, and would defend their value in bringing about appropriate social change and individual improvement. Nevertheless, while most of these assumptions had a traditional usage behind them, the MHCDs usually refrained from formally stating and studying any of them as guiding principles.

In Viet Nam (July, 1967, to July, 1968) the author found that some of the effective management of military psychiatry problems proceeded as if these same principles applied. This was particularly apparent in the MHCDs of the combat divisions. Each of these principles has been discussed separately somewhere in the literature and seminars of military or community psychiatry, but have never been Euclidized into an ordered system for understanding and managing psychiatric problems. This paper is an attempt to collect these principles or assumptions into one place for examination and discussion, before proceeding to detailed examination of psychiatric cases managed in the light of these assumptions.

These principles and their discussion do not necessarily constitute any official policy of the Army, but it is hoped that the publication of this author's views of them may stimulate mental health staff to contribute further to the organization and the appropriate evolution of psychiatric management principles. The present paper will give a rather simple-minded definition of anxiety to render more understandable the summary of the general principles. After that, the principles will be expanded and enlarged by examples.

II. Definition of Anxiety

For this paper's purpose, anxiety is a feeling of restless discomfort or vague apprehension in an individual (or in a group), as if the subject were restraining himself (or itself) from performing some act or experiencing some pure emotion. Thus a mother might restrain herself from experiencing anger at her baby. The subject is less anxious in that he is plagued by the energy of that emotion--the high blood pressure, the rapid heart beat, the alertness that should accompany the emotion. Avoidance of feeling the emotion itself or

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* The author is currently Training Program Advisor for the State of Illinois Department of Mental Health. At the time most of this paper was written (1968) he was stationed at Long Binh as Chief Psychiatrist for U.S. Army Vietnam. Most of the observational data was collected during 1965-67 while the author was stationed at Walter Reed Army Institute of Research. The data was confirmed in principle by observations upon combat psychiatry practices in Vietnam.

of performing any act appropriate to it allows the subject to maintain a posture which convinces others (and therefore himself) that such feelings or acts are not the sort of thing his real self does. The self image is maintained even though the subject has great need to feel and act other than the self image would imply.

The mother who is stimulated to be angry at her baby, however, may maintain a good mother image within herself and yet not be plagued by the free-floating energy (anxiety) of that anger's emotion if she channels that energy into some symptom. For instance, such a symptom might be a medical complaint or some pain, which in effect punishes the mother while at the same time it brings personal care and attention to her. Perhaps she felt that the baby had been getting the lion's share of such attention. Another reaction is to pamper the baby, or perhaps expend the energy of the feelings upon scrubbing the floors. It is even possible for the mother to act from the anger itself, without destroying her image as a mother, if she "accidentally" injures the baby, or if she attacks the baby and then has amnesia for what she did, as if to say, "It wasn't really this me who did it--it must have been some other me."

Anxiety here is not an emotion, such as fear or love or hate. It is merely the energy behind that emotion.

III. Summary of the Mental Hygiene Assumptions:

1. Within the individual, anxiety is transformable to symptoms, to acts, or to expressions of emotion.

2. Anxiety is transferable from one individual or group to another individual or group.

3. Symptoms are transferable from one individual or group to another individual or group.

4. A symptom (or anxiety) is a communication from a certain group to another group, and at the same time it is a communication from one individual to another individual.

5. The particular symptom which pays off best to the individual becomes most permanent and persistent in him. Payoff to the individual's group has more influence on an individual's symptoms than direct personal payoff has.

6. The symptom comes to rest most chronically in the particular individual who can resolve the most group needs with that symptom.

7. The individual and group (the family or military unit) regularly act as if the aim were to maintain the individual's illness.

8. A symptom or act of an individual is especially apparent in certain social situations, and cannot be maintained at all in other situations.

9. In any society there is a limited social vocabulary of symptoms and of responses to symptoms.

10. A diagnosis manipulates both the patient and society by affecting roles, attitudes, and behavior.

11. Once the psychiatrist has made public a diagnosis the individual or the social group may use the diagnosis as a lever to manipulate the psychiatrist.

12. A diagnosis clearly proven for an individual while he is a member of one group may be false when he acts as a member of another group.

13. A psychiatrist performs best when he is under creative supervision of a fellow not responsible for the particular case.

The general assumptions above seemed to apply to the field and garrison troops and to the few dependents handled directly under the supervision of their MHCDs, whether in hospital, clinic, or neighborhood settings. The assumptions applied also wherever MHCD acted as consultant on the far greater number of dependent problems handled by Army Community Services, Legal Aid, Red Cross, personnel sections, or civilian institutions.

IV. Discussion of the Principles

1. Symptoms (or anxiety) are transformable from one type of symptom to another within a single group or individual--or they are transformable to expressive acts or emotions.

a. Within a military unit the prevention of a high rate of unnecessary sick call may result in a high rate of AWOL. Making AWOL itself impossible may increase fights, thefts, drug use, or accidents. In desultory, poor morale troops, Command may decrease a high malaria rate by forcing the men to take suppressive measures, but this action may result in a high rate of accidents and preventable wounds. A student group responded to what it thought was unjust harassment by having its best scholar show up drunk for class. Another student group had one of its members attempt suicide, and later it manifested the failure of its six brightest students.

b. Within several individuals, anxiety was converted into overeating, which resulted in obesity. As they tried to reduce weight, the obesity was transformed into excessive smoking. In other individuals, headache was transformed into aggression when they loosened up and expressed themselves. In others, hypochondriasis gradually metamorphosed into paranoia; insomnia into drug habituation.

2. Anxiety is transferable from one individual or group to another individual or group.

a. A paratrooper in training was afraid to jump. His platoonmates ridiculed him, thus strengthening their own faltering courage. At the same time, they increased the anxiety in the trainee by rejecting him from the group, while still restraining him from hating the group. The platoon anxiety thus became condensed into this one failing trainee.

b. An anxious soldier, about to begin a combat mission, was reassured by other men, who were really reassuring themselves. They saw the first soldier as the one with anxiety--not themselves.

c. A student apprehensive over an impending examination rid himself of anxiety by asking another student if he knew the answer to a complex question. The second student then anxiously scurried through his books to find the answer for himself. The first student relaxed and smiled: the anxiety had been transferred.

d. A training workshop aimed at developing creative planning skills among several groups. The groups elected representatives to communicate with other groups or with a congress of group representatives. It was very hard for each group to delegate to one member full authority to commit the group to action. Once a group elected this plenipotentiary delegate, however, the group members behaved like irresponsible children, talking of irrelevant things, expecting that the delegate would work magic for them. It appeared that each member had taken his own anxiety and responsibility and stuffed it into the delegate. The plenipotentiary delegates themselves, when interviewed, declared that they had lost good communication from the group and had developed an inner feeling of resentment at having to carry a responsibility which the group members themselves no longer felt.

e. Several professionals--in both medical and Command specialties--described what may amount to a delegation of their individual feelings to an imaginary group. They spent a lot of effort at various times writing scathing editorial works which they never published, but the writing relieved them of certain strong feelings, as if some outside groups were now carrying that feeling, and the responsibility to act upon it.

f. An office chief, under pressure to get a record system organized, transmitted to his subordinates most of his own feeling of urgency but not the expectation that they could use any ingenuity and innovation greater than his own. Thus the subordinates developed an unproductive emotional tenesmus (anxiety). They became effective again when, with consultation, the chief actively expected that his subordinates would be more ingenious than he alone could possibly have been.

3. Symptoms are <u>transferable</u> from one individual or group to another individual or group.

a. A wife, very angry and lonely that her husband was overseas, could not at first eat or sleep well. She talked to her 3-year-old son in such a way that he exaggerated and retained beyond the natural time his personal disturbance at father's absence. The child began to soil the bed, to lose weight, and to talk to himself a lot. The wife then showed concern only about the child's symptoms.

b. Soldiers who felt great stress at work but did not dare complain, were so obnoxious to their wives and children that one child developed recurrent spasms of the eyelids, one wife developed colitis, and another

severe headaches. The husband of the last wife had had chronic stomachaches, which went away when his wife developed headaches.

4. A symptom (or anxiety) is a communication from a certain group to another group, and at the same time, from one individual to another individual.

a. A patient appearing in a clinic with a headache is communicating directly to a single person--the medical officer--the patient's own personal problem with his work, let us say. The patient may be flooded with more conflicting problems than he believes he can handle. At the same time he is a spokesman, perhaps unwittingly, for his whole crew or unit which may be saying to the Medical Corps and to Command, by means of his headache: "Look what pressure we are under. It's giving some of us dangerous headaches."

b. Fear of heights developed in a wife who had to live in a 4th floor apartment. This symptom was a communication to the Medical Corps that she wanted to live on the ground floor like the family of her best friend. Actually her husband was more irritated than she but his own complaint got no attention. At the same time, the symptom was equally a specific communication from this particular lady to her personal physician. Bleeding wrists from several wives on different posts seemed to be a communication from wife to husband that she wanted him to change his behavior. The gesture was at the same time a communication to the Medical Corps, and thence to Command, that action must be taken to relieve her and her family. In one instance the sponsor's unit members complained to their supervisors that work was so hard and hours so long that some of their wives were even driven to suicide.

5. The particular symptom with the most payoff to the individual becomes the most prominent and persistent symptom. The payoff to the individual's group has more influence on the individual's symptoms than direct personal payoff has.

a. In posts where the local society was inordinately concerned over the mental health of children, children got psychotherapy twice as easily as adults. Families on such posts had a strong tendency to shift their anxieties onto one of the children. The child then had the anxiety drained off in clinic therapy, and returned to his family for a refill. The child health workers, when unwary, tended to see the problem as a pedocentered system, in which all the psychodynamic forces revolved around the child's position. Workers with a broader view saw the child as a planet among equal planets in this system.

b. On a post where it was the current style for overworked wives to have migraine, the clinic observed relatively little frigidity, alcoholism, stomachaches, insomnia, "weak heart," etc.

c. A husband overseas without his wife was unsympathetic to her phobias and headaches but was jealous of possible lovers. The wife felt impelled to seek lovers for sexual relief unless he came home right away.

She told him that in a letter, then appeared at the MICD with her sexual complaints.

d. Where fear of high places was not considered locally a reason to move families to the ground floor apartments, those families who hated to climb stairs developed wives with palpitations, backaches, and vertigo, but not phobia. Many times, companies experiencing a tiresome field maneuver produced affidavits from members declaring that a sick member had his mental breakdown solely because of the stress. "It was enough to drive anyone out of his mind." The implication was, "I didn't break down, though; look how tough I am and how much special consideration I should get for going through such stress." The company itself had developed symptoms in the form of patients which would get special attention. Stress, of course, evoked several kinds of symptoms, but the symptom most emphasized was the one which Command and the Medical Corps attended to most dramatically.

e. A psychiatrist new to the Army was sent overseas to be the only psychiatrist in a rather wide area. In his first month three men made suicidal gestures. He hospitalized them all for two to five days. The next month there were ten suicidal gestures. The following month there were fifteen, and the next month another fifteen. At that point the psychiatrist decided to hospitalize no more suicidal gestures, and he let the community know this. The following month there were only three gestures, and for the rest of his tour there were only one or two suicidal gestures per month.

f. Two young recruits failed to salute their commanding general as he came on the post one morning. The general called them over to his car and asked them what the trouble was. They said, "Oh, sir, we didn't see you." The general then ordered them to go to the hospital and have their eyes checked, and if there was nothing wrong with their eyes he would personally tend to them. The hospital examination revealed one recruit had 20/200 vision in both eyes, and the other could barely distinguish light from darkness, yet records showed that two weeks earlier, when they first came on the post, their visions had been normal.

6. <u>The symptom comes to rest most chronically in the particular member who can resolve the most group needs with that symptom.</u>

a. A wife can usually get a doctor's attention about a vague complaint much more effectively than her husband can. In the military, more wives than husbands received chronic treatment for mild to moderate impairment.

b. The symptoms of wives or children rather easily effected a transfer, curtailed a tour, or got quick housing. A similar symptom in the husband often got him a discharge or a less desirable job.

c. A symptom sometimes allowed a family to avoid frightening chores or sexual relations, and to set up a new pattern of relationship which the family desired--often desired with uncertainty and mixed feelings.

d. Several cases of obstructionist behavior were referred from one company. There was excessive sick call, loitering, borderline discourteousness, and careless accidents. Exploration of the company's problems revealed that the company commander was neither liked nor respected by the company as a whole. When the commander, with the help of his own supervisors, changed his style of communicating with his troops, the problem rates decreased. Some mental hygienists explain this sort of "epidemic" as due to emotional pressure from the majority of the unit upon a few people who are not likely of themselves to commit these obstructionist acts. Others explain it as due to the fact that there is always a group of passive-aggressive people in any unit, and these people are normally restrained by the rest of the group from acting in an anti-social manner. Often their inappropriate behavior is laughed down before it really gets started. But when the group needs such acts to occur it merely fails to keep these men in line.

7. The group (the unit or the family) and the individual regularly act as if their aim were to maintain the individual's illness.

a. Attempts to get people together who contribute positively or negatively to the illness were often met with great resistance. Many times the units and families said in effect: "The clinic has set itself up as a caretaker for individual emotional troubles. Now the clinic must treat exactly the persons we throw up to it and not try to change the rules of the game."

b. The caseworker or psychiatrist often became integrated into the social system which maintained the illness. He chronically skimmed off the cream of the anxiety so that the family, the school, or the unit could continue to stagger alone.

8. The symptom or attitude of the individual is especially apparent in certain social situations but cannot be maintained at all in others.

a. Several times the patient who was mentally the sickest on the ward and was nursed by the other patients began to function better and took up a nursing role himself when an even sicker patient became a ward member.

b. Members working with indigenous people in Germany, in Korea, or in strange parts of the U.S.A. complained that certain dialects, sound, and phrase patterns seemed irritatingly silly, prissy, or doltish. After working in the region where that dialect was proper to the society, the members adopted that very manner themselves and said it felt a natural part of their true selves.

c. When the total membership of a ward decides to maintain an attitude which changes the meaning of patient "A's" behavior, then "A" may no longer be able to maintain that behavior. Thus in a ward meeting the staff and patients decided to adopt a certain constant attitude toward a depressed patient in order to move him out of depression. The group assigned him the task of sandpapering a board 10 hours a day,

while all the ward members maintained a gentle but firm guidance upon the minute details of his manner of performance. After two days the patient could no longer maintain his old depression. He threw the board across the room in anger and began to interact responsibly with the other members. His feelings in this instance seemed to be determined by the social context in which his feelings occurred.

9. Each society maintains a definite vocabulary from which psychiatric symptoms may be conceived. In order for a symptom easily to get attention or to change the behavior of other people toward the patient, that symptom must be in the community's current vocabulary of significant symptoms. This is similar to the fact that a verbal communication must be in English to get an appropriate response from a doctor who speaks only English.

a. In most military communities, a patient who consistently complained of a backache was attended to for many visits, and given many tests and examinations, even though no pathology was ever found. After a long time some of these patients were considered neurotic. If they complained with great perseverance they might even be considered psychotic. But a patient who complained two or three times of a nose-ache, without organic findings, was quickly suspected of being psychotic.

b. Patients who attempted suicide by cutting their wrists, notwithstanding the inefficiency of this gesture, were considered in style and rather seldom psychotic, but those who cut themselves with equal inefficiency in some unstylish part of the body, such as the crotch or head, were quickly suspected of being psychotic.

c. Forty years ago the systems of neurocirculatory asthenia drew considerable professional attention. Now it is not even a recognized disease. Some of the symptoms, such as palpitation, that once composed it are now minor manifestations of some more stylish syndrome, such as "anxiety with hyperventilation," or "acute situational reaction."

d. There was wide difference in the meaning that the medical professions in different cultures ascribed to the "Evil Eye" or to the need of a worker to have three weeks of balneological treatment once a year for some equivalent of "tired blood." --Or to the effect observed in acupuncture or to the necessity for prisoners to have sexual relations. In Italy and Sicily the "Evil Eye" had a strong medical effect. In Germany the "baths" had strong scientifically proven effects they did not have in the U.S. The same applied to acupuncture in the Far East. In Mexico and in Africa it was considered necessary for mental health that prisoners have sexual relations. In the U.S. it is usually assumed that anyone in jail, hospital, or old people's home has no real necessity for sexual activity.

10. The diagnosis manipulates both the patient and society by affecting roles, attitudes, and behavior. MICDs considered that a diagnosis was a social gesture by a doctor in response to the individual's symptoms, and influenced also by pressure from social and professional groups, such as the patient's family and community, the doctor's professional association and other doctors in the locality.

A psychiatric diagnosis tended to deprive the patient of his community's acceptance of him and its feeling of responsibility for him. He became estranged from the normal agencies of socialization and production. For the community usually reacted as if it had given over to the medical profession alone the work of curing the individual. Sometimes the best service that the medical staff could render was to link the patient with family, neighborhood unit, special services, and other resources in the patient's natural living and working community.

Even in true mental disease, most MHCDs considered the level of social functioning more important than the diagnosis alone. Chronic schizophrenics have run efficient civilian businesses while hallucinating, yet some passive-dependents have been unable to dress themselves. A practice found among [illegible] experienced MHCDs was to give the sort of diagnosis (or lack of it) which will lead to the most appropriate disposition. For example:

a. If long-term therapy was desired for an interesting dependent, a neurosis might be diagnosed.

b. If administrative or judicial management was most appropriate, then a character and behavior diagnosis might be made.

c. If hospitalization or medical evacuation was most useful, a psychosis might be diagnosed.

d. If a fairly quick and functional acceptance of duty or community was desired, then all psychiatric diagnosis was avoided.

A diagnosis tended to strengthen the disability, socially. If a patient's unpublicized diagnosis was considered of major importance by attending staff members who talked about it, then the medical community acted toward the patient as if the diagnosis were published, and the same effect prevailed.

11. The group or the individual may use the diagnosis as a lever to manipulate the psychiatrist.

a. Some of these procedures are explained above. The case of the doctor who hospitalized suicidal gestures is in point.

b. There were many examples of people diagnosed as schizophrenics who utilized their diagnosis in order to act irresponsibly with impunity, even though their schizophrenia had nothing to do with the irresponsibility.

12. A diagnosis may be true for an individual while he is a member of one group but false when he is a member of another group.

a. For instance, a child was so chronically disruptive and aggressive in school that he was given special medical treatment for hypomanic state. The treatment was effective. Nevertheless, the child had never been disruptive at home but had gotten along normally with children and adults at play and work.

b. A husband was a heavy drinker on weekends and some evenings when he was at home--sometimes injuring his wife and children so that they eventually could not live with him at all. Nevertheless at his work he was always perfectly effective and never under the influence of alcohol.

c. A young American was frightened of women but effeminate in his manner and had sexual relations only with other men while in the United States. In Japan, however, he adopted an attitude consistent with normal American male image, had no sexual relations with men, but frequently went out with Japanese girls, eventually marrying one and living happily with her as long as they were in Japan. About a year after his return to the States with her, he became dependent and effeminate and again developed homosexual activity. The couple returned to Japan, where the husband again became normally masculine in his behavior for the next year, and maintained a responsible attitude as head of the family. After that year the husband may again have changed his behavior. Nevertheless, for shorter or longer periods such a person was able to maintain quite a different "diagnosis" in one group from that in another.

d. Many clearly schizophrenic patients were evacuated from Germany, Japan, or Viet Nam. From the first day of their arrival at a U.S. General Hospital they were clearly character and behavior disorders, or else were perfectly normal. The same phenomenon was observed when the medical department moved schizophrenic patients from a combat division MHCD to a treatment center outside the division, though still within the sounds and dangers of combat.

13. A psychiatrist performs his best management of patients or his best consultation to Command when he is under productive supervision. Such supervision does not relieve the psychiatrist of any responsibility; neither is it a peer review. It is collaboration or conferring concurrent with the management of the professional problem. It never obstructs the management process. The collaborator need not have the same rank nor even the same professional specialty as the responsible therapist or consultant. Thus, social work officers who were captains professionally supervised psychiatrists who were majors. Without such collaboration the relation between therapist and patient may become an isolated system, secreted from access to the objective thinking power.

A very effective psychiatrist who was a lieutenant colonel daily presented his therapy sessions with a difficult patient to another psychiatrist who was of lower rank and less experience, but who was nevertheless a capable and responsible professional, able to view the case quite objectively. Both patient and therapist benefited.

A young medical corps captain acting as a human relations consultant to an artillery battery, used as monitor and conferee an old medical corps sergeant who had wide experience in Command consultation.

Discussion: Traditional psychotherapists who only saw individuals, or even families, in clinic offices could work for years without seeing any evidence of the above principles nor any need for them. Every observation could be

explained in terms of the psychodynamics within certain individuals. The consultants, counselors, and therapists who visited and worked with individuals, families, crews, and organizations in their homes, barracks, work sites, classrooms, etc. were the discoverers and users of these principles. This experience led them to effect interventions which often differed paradoxically from the traditional.

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY VIETNAM
APO SAN FRANCISCO 96307

16 October 1967

Dr. Nathan S. Kline
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Dear Doctor Kline,

Luckily you have written to the right person for information concerning civilian psychiatric care in Vietnam, for I have been here only 3 months and know almost nothing about the country - just a few haphazard observations and lots of hearsay, no organized overview of social problems or psychiatric management problems. Therefore I can write you a whole book on the subject.

Now if you had asked someone who had been here 3 years, you would be unlikely to get this. Most such people I have seen talk with great discrimination telling only what their listeners can tolerate hearing and believing. I am absolutely certain that I have a very distorted view. I don't know the significance of 1/10 that I have seen and I have seen very little. But I surmise that you think some communication on the subject is better than none so I am going to say some things off the cuff hoping you will realize that 3 months from now I will almost certainly have many ideas contrary to these. I cannot even guarantee that I am spelling people's names right. Do not assume that anything in this letter is necessarily official policy or established practice of any U.S. or Vietnamese agencies.

Concerning your obtaining further information: The government of Viet Nam apparently prefers that you make approaches through their established channels so that heads of government (U.S. and Vietnamese) are always aware of what you are up to. I think the Vietnamese government, like most Far Eastern governments, will be aware anyway through the same sort of "grapevine" which enables them to find terrorists we could never find in the U.S. But if you don't keep straight with them you can hardly do any lasting good.

The military channel here is the Military Advisory Command Vietnam. I deal in these matters mostly through COL Robert Hall, surgeon. Hq, MACV, APO San Francisco 96307. There is quite a bit of cooperation at the local provincial level between American military physicians and

civilian medical and technical personnel. Of course they must deal with some psychiatric problems but they are not in psychiatric institutions. There is at present only minor contact between American military psychiatrists and the 4 psychiatric services that I've heard exist in country.

I would suppose that your own main channel of communication is through the U.S. State Department. Most of the action under this department is carried out by USAID. I don't know of any psychiatric work USAID is involved in because I haven't yet talked with that agency.

There are many American civilian physicians working in Vietnam. As a pure guess I'd say a thousand. They are usually with some agency such as Christian Missionary Alliance, Medico, USAID, etc.

There are many other free world countries who have physicians working in country.

At this point I have come to believe there are only 4 Vietnamese hospitals with psychiatric services:

(1) Cong Hoa hospital on the outskirts of Saigon. This is a military hospital but takes care of some civilians who are associated with the military. It has about 80 neuropsychiatry beds but often these beds hold over 100 patients. It is not unusual in Vietnam to have 2 patients assigned to one bed. The NP service seems also to care for quite a few leprosy patients (in maybe 50 additional beds). Some of these leprosy patients are juvenile. There is normally only one psychiatrist, CAPT. NGUYEN DUY SAN, MC. (Remember that though NGUYEN is his family name, a doctor is normally addressed by his given name. So he is Doctor San.) There is also a neurologist on the ward and at present an OJT psychiatrist. The ward is relatively well housed and managed and consists mostly of long porches open to an inner court and with many 3 - or 5 - bedrooms opening onto the porch. There are several big seclusion rooms. I thought the most conspicuous problem was the lack of adequate outdoor recreation area and of occupational therapy. Most psychiatric patients in Vietnam seem to concentrate most of their emotional concern upon some physical symptom, often palpitation, headache or gastrointestinal complaints.

(2) In downtown Saigon is Cho Quan hospital which handles relatively acute cases of infections, disease and neuropsychiatry. This amounts to something like half leprosy and half NP. The Chief is Doctor Tiep. There is a large psychiatric outpatient clinic. There must be about 200 in-patient beds, most of which are managed by an American woman psychiatrist with 1 or 2 years of psychiatric residency and who is there under some religious auspices. Her name is Dr. Strayer and her husband works as an engineer in Saigon. She has been here something less than a year, I believe. With her is Miss Anne Falk, an occupational therapist, and also an American male social worker whom I have not met. Dr. Strayer said she came over to RVN thinking that she'd be a sort of understudy helping other psychiatrists.

Theoretically Cho Quan NP patients stay there only about 3 months. After that they are sent to Bien Hoa Mental Hospital which is the only large "state hospital" in country.

(3) Bien Hoa Mental Hospital is about 25 kilometers outside of Saigon. It has 1200 beds and 1300 patients. It has ample grounds with a small river coursing through and affording a very important source of water. Many patients do their bathing and laundry in the stream. The chief is Dr. Anh, a French-trained psychiatrist. There is one other full time psychiatrist, Dr. Steinmetz, an American who has been there about 8 months. There is an acute admission pavilion housing about 200 patients and a prison pavilion housing perhaps 150 in 2 bare rooms.

The patients who are least sick live in 10-man cottages surrounded by little plots of vegetables and flowers which they cultivate for themselves. They are, of course, free to come and go. In general it seems that patients leave the hospital when well enough to accept their families and to be accepted.

Most of the direct management of patients is done by "trustee" patients and they are trained and supervised largely by attendants along with about 3 trained nurses and a number of nuns who seem quite conscientious but have no special training. The response to nurses depends on the patient's cultural background. To most men an older sister is a benign authority. An agitated man usually sees a nurse in the role of older sister and responds with docility. In some "cultures," however, no man ever obeys any woman. Such men are harder for nurses to handle. There are many other ways in which cultural roles, often differing widely from ours, are utilized in this hospital.

(4) The Provincial Hospital at Hue in the far north of South Vietnam has about 25 NP beds and is used for teaching by the Medical School at Hue. The psychiatrist and some other teachers in this medical school are German nationals maintained here by the West German government. The psychiatrist is Dr. Erick Wulff who has written some things about how he thinks psychiatric symptoms are affected by the mother tongue of the patient. I haven't yet met Dr. Wulff. There have been some overtures toward having medical students from Hue and from Saigon come to Bien Hoa Mental Hospital for clinical training in psychiatry, but medical students don't come as yet. Some coordination difficulties arise because hospitals are under the Ministry of Health and medical schools under the Ministry of Education.

The medical school in Saigon was, I believe, moved in from Hanoi some years ago. The teaching methods are continental--long on theory and lectures, short on laboratory and practicum, very authoritarian. They are rapidly changing, possibly too rapidly for social and political comfort. They have a large new ultramodern building now, and the various departments are sponsored each by a different American medical school. The actual lecturing is still done by Vietnamese and French professors and attempt is being made to conduct classes in Vietnamese instead of French. Most of their library is in French and English. Their teaching of psychiatry seems to be as yet

almost entirely literary.

Dr. Norman Hoover is in Saigon as the field director of the AMA project with the Saigon Medical School, APO San Francisco 96243. Dr. Tua, a woman, is dean of the Medical School.

I think it's absolutely essential to understand this situation culturally. Psychodynamic concepts which are supposed to be universal don't always apply in parts of Southeast Asia. One thing that has apparently been a problem is the Western idea that groups are made up of inviolate, autonomous individuals and that every individual should be self-sufficient and self-respecting in a Western sense. Seemingly more valid here is the Confucian idea of the individual as a part of a harmonious extended family and community--extended too into the distant past. This probably seems so to me because it is the closest philosophy I know that fits what I observe here. I'm sure there are much more accurate formulations.

I have the impression that the Vietnamese psychiatric personnel, seriously committed to their work, have become a bit exasperated by Americans who come in (as perhaps under the AMA volunteer program) stay two months taking 6 weeks to get their feet on the ground and then starting some important project which the community cannot continue when he has gone. Some Americans know how to get a sort of delusional satisfaction from anything in which they've invested a lot of emotion. They will hang onto a theory developed in their own country or class in the face of all kinds of evidence that it does not apply in another country. This may account for Bien Hoa's discontinuance of the AMA volunteer psychiatrists there.

Most Americans who have not served more than a year or so in the Far East seem to believe that America has the most knowledge and skill and the best equipment for any human use; and if the people of another country don't resist too much, we should give it to them. Actually, working in the Far East is a little like intensive psychotherapy which changes the doctor as well as the patient. Some say that the psychiatrist who is not willing to change should not engage in intensive psychotherapy. Well, I think the personal change American psychiatrists will undergo here if they really become involved in this country's problems is far greater than the change they underwent from medical school to the end of their psychoanalytic training. The peculiar thing about this change is that when one of these changed Americans returns to the U.S. and tries to communicate to other Americans the attitudes and knowledge he has picked up, his whole surrounding society begins to tell him what he must really mean and what he really experienced. Soon he "gets with" the people at home and his Far Eastern attitudes become dormant.

I have felt, from other years in East Asia, that to most American psychiatrists a personal change of class or culture is equivalent to death and carries the same fear. Furthermore to move from a rural orientation to an urban one is seen as a matter of maturing. But to adapt a more rural orientation is felt as a regression. Thus many American psychiatrists assume

that the proper human grammar of thought and behavior is that of the city and of the middle class. They see Vietnam as Saigon and its satellites. They see East Asians as developing Europeans. If they sit on a floor and eat rice and fish sauce with chopsticks they are only play-acting temporarily "--This is not me." If these psychiatrists could become more flexible trans-culturally, they would develop much of the breadth that the U.S. at home needs in its psychiatrists. Practicing a profession in Boston for several years does not equip one to practice it even in Bien Hoa much less in the mountains. A man who thinks he has become an expert has really become part of a system--a man-in-his-group-in-its-landscape. The man who moves out of his group or the group out of its environment suffers a change. Moving around within the U.S. forces relatively little change because the U.S. is easy to conceive of as one great city. But a man moving from his role in a Boston system to one in Southeast Asia becomes a heterologous transplant and doesn't take well. Though most of us really expect Southeast Asia to adapt to us, I believe that unless the psychiatrist immerses himself in this social climate, temporarily suspends his Western identification, meets with a crisis, has a sickening cultural shock and keeps going through it anyway, he won't get what this place can give him. To learn these things is analogous to an English teacher's learning a foreign language the better to teach English. The import of the Far East in this is that most English teachers are satisfied to learn French. And even if they don't encode it--don't merely learn French equivalents for English expressions, but learn to emote in French grammar, they haven't much strained their personal orientation. It is still European. But let them learn Chinese and they learn for the first time a written language, not just a flow of syllables put on paper. Ideas are floated onto the awareness without the rigid determination of which is thing, which action, which describer. Tones and pitch patterns are freighted with far more denotative meaning than in any European communication. Grammatical gender, number and person seem non-existent. The Vietnamese language too is a gulf away from English. I bring up these thoughts to indicate the gulf between Vietnam and America--a gulf that stimulates the highest of learning processes once it is accepted. I'm not advocating that we be meek and humble, only that we commit ourselves here and not merely come to pick up the aura of one who has been to the place the world now attends to with such controversy and emotion.

I would also advocate that anyone interested in being any real use to the country should stay at least a year and become a part of a fairly large group whose members have overlapping tours and come and go without causing discontinuity in the group's development. Such a group-landscape system can rapidly convert a new member and educate him.

But what about the place of psychiatry in Vietnam? For all that their ways may seem peculiar to the West, the responsible provincial leaders in Vietnam have a broader view of the national problems than most specialists. I wonder at the weight of new mental health activities in a scale of problems

Dr. Nathan S. Kline

which must run something like this:

War - 100 tons
Commerce (including food and transport) - 10 tons
Education - 2 tons
Malaria - 200 pounds
Cholera - 100 pounds
Plague - 100 pounds
Tuberculosis - 100 pounds
Leprosy - 20 pounds
Trachoma - 20 pounds
Mental disease - 5 ounces (?)

Americans, feeling little pressure from those bigger problems preoccupy themselves with problems which are relatively tiny among Vietnam problems but get big attention in the U.S. where they are domestic problems. In other words, by projecting our own problems onto Vietnam we blind ourselves to their big problems and magnify minor problems such as prostitution, class inequalities, venereal disease, narcotic usage, governmental efficiency.

Now I'll hurry to nail this before I have to revise it completely in the light of new observations.

Sincerely,

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THE USE OF THE LOCAL COMMUNITY'S OWN ENERGY AND INTELLIGENCE IN ITS MENTAL HEALTH PROGRAMS*

Matthew D. Parrish, M.D.**

This paper sets forth impressions upon the informal and non-official practices as observed on visits to and work with both government and private mental health facilities in several states. Fast developing institutions naturally find their formal and official practices at variance with some of the informal. Sometimes the formal are changing over and sometimes the informal.

Most articles and books on community psychiatry are written by people who see themselves as going out to a strange community and helping the local people to manage their own psychiatric difficulties.

This attitude is a natural one in any professional, for professionals hire out their skills to clients who need help (to strangers, not usually to people who are very close). This general attitude is prevalent in our entire Western world today. For example, AID workers, U. S. Army Vietnam, the Peace Corps, and those social action workers who go to Southern states to help them with social justice, all seem to have the underlying attitude that they have something to offer the local people but the local people have nothing important to give these outside workers.

It often may appear that the professional experts know from their long experience and study what is best for most communities. Big government money pays for their going into a local community and helping the people to do what's good for themselves, and if the people don't know what's good for them, then the experts set up programs to inform them what they ought to ask for. These educational programs usually publicize local mental health statistics and set forth well known principles of community psychiatry. When the expert creates this general image, the local people identify his project with big government or big business--aloof, impersonal, overbearing... "The Man"..."Not like us..."

But a good mental health service in any local community is really a dialectical development between the hired experts and the local people. An example of such dialectic occurs when the local community or some interested group in the community forms a board which can negotiate with mental health experts in the setting of policy. This Mental Health Board usually includes representatives of the school system (including private schools, nursery schools, and vocational training programs), Mental Health Association, churches, trade unions, courts, etc. Many such boards have a healthy tendency to invite to their membership any loud but responsible complainer about the mismanagement of mental health projects. Some mental health professionals, however, hate to work with this board of ordinary citizens which has the power to hire and fire them. Such professionals consider a secure job with high prestige more important than a continually improving service to the local citizens.

A useful principle of community mental health: Great mental health principles forced as policies and procedure upon the local community for its own good have less effect than somewhat poorer policies and procedures developed by the local people and enthused with the [illegible].

* Addressed to Workshop for Volunteers, Adolf Meyer Zone Center, Decatur, Illinois, April 18, 1972.

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Not only does the community through its Board help set the Mental Health Center's policies, but the community's mental health system is invited to send one of its members--either an old board member or a mental health expert--to sit in on groups which plan major community actions affecting human relations--for example, school, police, and housing policy.

The professionals in the Mental Health Center investigate especially certain special problems and help local workers to arrange their solutions, e.g., the delinquent children seen as a problem by a school. The Mental Health Center may work then with the community forces involved in this delinquency--both those forces contributing to that delinquency and those opposing it, e.g., the children themselves, their peers, their families, teachers, the police, the recreation and welfare systems, pediatrics... but this work of the professionals is only guidance and consultation and is in itself not usually sufficient to satisfy the community. Professionals cannot cure the problem by only being objective and scientific about it and participating in the management and planning. Professionals cannot cure the problem by giving treatment to the individual child so that this particular child is no longer delinquent; for this treatment turns out to be so expensive that no community has been able to afford management of its child problems by treatment of the individual children. Such treatment, moreover, does not prevent other children from becoming the delinquents when the first are removed from that behavior pattern.

The Mental Health Center's main efforts are accordingly directed at the informal and the formal influencers of the deviant, of the mentally ill. The informal influencers of an adolescent, for instance, include family, fellow students, neighborhood co-workers and gang or team members. None of these people are paid for maintaining their informal relationship. The formal set of influencers includes teachers, bosses, doctors, police, vocational workers, etc. These workers are paid to maintain this fixed and formal relationship. With the formal influencers, the Mental Health Center usually works by the classical form of consultation as described, for example, by Caplan.[1] With the informal influencers the Mental Health Center works by utilizing (1) volunteer workers, (2) locally recruited and paid neighborhood workers, (3) infiltration of community groups by Mental Health Center personnel, (4) natural neighborhood groups dealt with directly as groups. Some Mental Health Centers, for instance, have themselves set up to handle emergencies before their inpatient wards were in operation. The mental health workers then may have to sit up at night with patients, or participate in family, police, or school efforts to contain the problem. They cannot merely admit the patient to the psychiatric ward machinery to let him develop a hospital personality and to let the neighbors get used to his being no longer a neighborhood responsibility. Without a ward, the patient-neighborhood system cannot settle easily into accepting the chronic non-functioning of its member.

(1) Volunteer workers are usually housewives who work part time doing mental health duties under the supervision of the Mental Health Center. They often help with the paperwork, with occupational therapy, activity group therapy, certain patient work procedures, public relations. A volunteer may remain right in her own home and get help to people with certain family problems, work problems, learning problems, addiction problems... The volunteer workers are often a

special help to the Mental Health Center when it invites the local neighbors in to an "Open House" or when the Mental Health Center and the local people combine to have a community picnic.

(2) Paid neighborhood workers include energetic and influential adolescents and also elderly men and women who are respected, as informal counselors in the community. They work full or part time and are paid by the Mental Health Center. They are recruited from the local neighborhood and remain in that neighborhood, carrying on, perforce, much of the work by barter--by making deals between people and families and businesses, etc., often including themselves in the bargain. The worker's reward is not merely the money but the enhanced prestige, the development of leadership, and other skills and knowledge, as well as contacts which may get him a better job in some other work. These workers are sometimes ex-delinquents themselves. They are usually given a course of training at the Mental Health Center and they spend an hour or so each day at the Center in order to exchange information and to make the necessary deals involving the other Center workers.

(3) Practically every professional member of the Mental Health Center belongs to some local community group, such as a long hair drama group, Kiwanis Club, etc. Out of this participation the professionals do not get money but they get enjoyment, learning, and perhaps special privileges as members of the particular group. Some even marry into local families. All of this activity makes the Mental Health Center itself melt in better with the community. The attempt here is not to build bridges between the professional experts and the local laymen but to allow a certain amount of miscibility so that the Mental Health Center is a part of the community, just as an old family is, or as a church, or a civic association.

(4) The Mental Health Center barters with natural neighborhood groups, such as a street gang, the war widows, the bunch at Kelly's pool hall, or the closely communicating neighbors who live on a certain block. When it gets these natural groups to negotiate with other groups, each group becomes enthusiastic about some mission--about productive work on something outside of self. Any group forging ahead on a mission can make firm the mental health of some pretty sick members within itself. Since the Mental Health Center with its volunteer and neighborhood workers, as well as its professional experts, has a member in almost every community group, it easily gets the groups to work with each other when enthusiasm develops in any quarter.

On a week's living-in visit to Dr. Maxwell Jones' therapeutic community at Dingleton Hospital in Scotland, the author found a synergy of local and imported workers. The so-called "Cosmopolitans"--sophisticated people ranging from psychiatrists to aides--came in from such countries as Finland, Italy, U. S. A., and India. They spoke a common social-professional language and seemed to belong to an international professional consensus rather than to any particular urban center. They would be pretty much at home with each other whether working in Australia or Sweden. The so-called "locals," however, were Scots from the nearby communities, with their rather strict religion, distinctive language, customs, and personal idiosyncracies. The dialectic interplay between these groups, with the patients forming an intersecting third group, promoted the community therapeutic effect.

Paradoxically, two opposite tendencies in professional work today improve efficacy. One tendency is the objective, analytical approach to problems exemplified in some computerized or automated services (banking, medicine) which render even more aloof the experts who guide service to the individual. For example, the surgical expert in a big hospital may operate on a certain individual only a couple of times in 20 years. The second and less publicized tendency is the "tribalizing" of small systems of service such as the service a Mental Health Center renders to a particular housing area. The health worker may have daily contact with the interlocking network of the gaming, bartering, loving, fighting, neighbor-supporting cluster of dwellings and areas for work and play.

Any institution, or indeed any group, tends to draw definite boundaries around itself. This is necessary, of course, if the group is going to have a separate identity at all and not merely merge into some others. Professionals especially like boundaries lest they lose professional and group identity. The stronger and more impermeable the boundaries, however, and the more different the group feels from other groups, the more it tends to project its faults on to some outside group, seeing that other group as the cause of trouble; the more, too, it seeks to build up its own power and size in accordance with Parkinson's Law. When a Mental Health Center merges somewhat with its community by methods like those suggested above, and when it sees itself and the community sees it as a cooperating part of a larger community system, then Parkinson's Law becomes less effective since everyone in the community feels he has a stake in the Mental Health Center. The volunteer workers and the neighborhood workers often come, learn, work a year or three, and then pass on with new skills to more lucrative work. Significantly, Mental Health Centers who are thus attached and loyal to their local communities, have such high morale among their workers that they have less difficulty in recruiting professional experts from the training centers. These training centers include not only universities but other good Mental Health Centers. Professionals who leave the Center maintain a certain loyalty to it and retain honorary membership as alumnae.

Many professionals find it hard to create such an attitude in their Mental Health Center. Theorists see the fault as one of poor selection and training of mental health experts. They seek a solution in a general school of community services in which medicine is simply one of the graduate courses and there is not so distinct a separation between the doctor and the technician. It appears, however, that there are actually two other problems. First, the general theory of mental health operations itself has set up a prestige gulf between doctor and social worker, between social worker and technician, as well as between Mental Health Center and police or school. Second, the doctors who were reared in a middle-class urban setting know the feelings of many of the "locals" only by looking at them from outside the local class. Even those doctors who were reared in the lower class now avoid that class--and the class often rejects them. Doctors who get into the fun of being "locals" as well as "cosmopolitans" can by example lead other health workers into enjoyment of close and effective work with local people. If doctors really do belong to the profession of highest prestige, then they of all people can afford to work closely with the locals.

SUMMARY

The most effective mental health centers, those with the highest morale among personnel, seem to be those which are most integrated into the local community and are managed by the local community leaders. Herein has been described the use of local workers and managers to work in their own community's mental health center.

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[1]Caplan, Gerald: Principles of Preventive Psychiatry, London, Tavistock, 1964, pp. 212-265.

Aug., 1967

TASTE: A Necessary Ingredient in the Genesis of Civilization?

By Matthew D. Parrish*

We are just emerging from an age which explained most social behavior as consciously planned economic judgment. Bury[1] was certain the Greeks fought the Trojan War to get control of the Dardanelles and the wheat from Colchis. Non-economic people, of course, have considered the war fought over a woman.

Today we see many evidences that societies often use poor economic judgment. Scientific evidence that cigarette smoking contributes strongly to cancer and other diseases does not make groups give up smoking. Auto advertisers make more sales when they appeal to prestige or sex or thrills of fast driving, than to safety, reliability, or thrift.

This paper's question: How much did reasonable economic behavior contribute to the genesis of civilization and how much did mere taste or prejudice?

Tonybee[2] discusses thoroughly how complex civilized life may arise and develop through a people's response to some challenge such as a rigorous climate, an attempt of former land people to make living and adventure from the sea, a military threat from a neighboring people... This pattern of challenge and response will be assumed here but not further discussed.

Archeological probing throughout Eurasia has indicated that for the most part the growth of civilization was a slow process in which discoveries and inventions made by each small village or nomad group were passed on eventually to groups and tribes with other languages and other climates. But in a few places like the Nile Valley and Mesopotamia, men crowded to form large long enduring communities based economically on an agriculture ten times more productive than that of hinterlands. But why did civilization become so much more sophisticated in these valleys than it did in the fertile plains like the Ukraine or the Ganges Valley, which today support a rich agriculture? This civilizing and urbanizing power of the desert rivers occupied the thought of many historians. McNeill's[3] discussion is an example.

Consider the inhabitant of the hills. The barely dependable rains watered his wheat. By means of a few inventions and discoveries--tools and cultivation techniques--he doubled the soil's yield. If he had a particularly favorable location, his descendants might live there for generations and develop quite a local lore about the best methods of farming and living there. True, a covetous tribe might raid the harvest. But the chances were that most tribes of the region knew as much concerning wheat culture as he. because dissemination of agricultural techniques was easy and one hillside was similar to another.

Consider the Tigris-Euphrates Valley close along the banks of these desert rivers where wheat could grow ten times more luxuriantly than up in

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the Assyrian hills. Whoever cultivated a strip of this herbage reaped a richer harvest. But of course covetous hillmen could come in force and steal the harvest or take possession of the land the same as they might take any farmer's property in hills or desert. Later the people of the desert valley, however, put together a series of discoveries which were effective only in that valley. They worked out irrigation techniques. Accordingly they turned wide stretches of desert into a rich garden. This wide land could now feed 100 times the population the original river bank could feed. Hillmen might still come and snatch away the harvest but if they destroyed the knowledge of irrigation technique the great garden would revert to desert. Whatever mighty races, whatever languages and religions took control of the valley, they must all preserve the technical machinery and knowledge or the prize garden would wither in a few days. Those techniques, furthermore, were useless in the hills. The community of the river valley became then a cohesive unit with great common interests unshared by the upcountry men. This technique of irrigation was not pure engineering. The mixture with religion, superstition, art, and family tradition led to the further investigation of nature and improved the culture of this rich and economically cohesive community. So gods were propitiated, riverboats launched, fortifications erected. Improved commerce obtained from the hinterlands the much needed wood and ores. When these technologies of transportation, communication, and government became highly developed, they passed on to wide areas of naturally arable land like the Ukraine or the Ganges Valley, which could then support a large, well managed community.

The desert river valleys like the Indus, the Nile, and the Tigris-Euphrates provided the challenge that resulted in spontaneous and original development of complex urban life. Places where grains grew well without irrigation provided no such challenge.

One conspicuous exception is the Yellow Plain of China. Here a highly sophisticated civilization originated spontaneously. Techniques did not move in from the Western River Valleys.

Needham[4] in discussing the origins of the Chinese civilization and techniques indicated the Chinese cultivated non-irrigated grains such as millet and barley for centuries before the people started onto that complex urbanizing track of "civilization." Just before the beginning of the "civilized" Shang dynasty in the Yellow Plain, however, wet rice culture reached that territory. The Chinese developed the Yellow River and its tributary, the Wei, into an irrigation complex similar to that of the great desert river valleys. Now why did the Chinese choose to challenge themselves with rice culture? Economically oriented people often assert that rice provided more calories per acre but if this were a reason, the oriental peoples of today should respond to the U. S. Department of Agriculture's efforts to get them to raise American corn (maize), which of all grains provides comparable calories per acre. Again some assume that rice may be easier to cultivate in the Yellow Plain, but of all the common grains, wet rice is the only one that requires laborious construction of level paddies and careful transplanting in order to get an abundant crop. Others assert that rice (when polished)

spoils less easily in the tropics than other grains do. In the climate of the Yellow Plain, however, wheat, barley, millet, and even corn and potatoes have adequate keeping qualities.

During my two years in Japan and Korea (in 1954-56) I explored this problem with many oriental people--this business of eating rice three meals a day. The universal answer was: "Rice tastes better." These people discriminated among various kinds of rice tastes. They could recognize the flavor of certain rices grown in certain localities and they would pay more for them.

To the omnifrumentivorous American this is hard to understand. It is so hard, in fact, that in every major famine of recent times the U.S. has sent shiploads of American corn to the starving peoples of Europe and Asia, who complain that the U.S. insultingly offers them animal feed. Suppose America had a famine and other nations started to help by sending alfalfa and cottonseed meal for our tables...or suppose they even sent us real delicacies like fried cockroaches...many Americans would choose to starve away--starve away in the face of such plenty. It appears that ancient Chinese folk knew more than modern Americans about how to live on insects, fungi, and weeds when necessary. They also knew the flavor of wheat and barley, but as a tasty staple for every meal--more important than white bread in the U.S.--they preferred rice.

But this rice culture required, especially in the Yellow Plain, the development of elaborate irrigation techniques. Without irrigation the fields would have to revert to the relatively undesirable barley and millet. Their desire for rice forced the Chinese to face irrigation problems similar to those of the Mesopotamians.

But why should the Yellow Plain have become the site where the high culture originated? Rice culture, after all, can utilize the water from almost any stream and there are certainly many streams in China. There are at least two reasons why the Yellow Plain became the center of civilization.

1. Rice culture along a small watershed can support a small community which does not necessarily interfere with nor cooperate with the communities of the neighboring watersheds. But the Yellow Plain was the largest irrigatable plain in China. A very large interdependent community would thus develop with necessity for close technological cooperation among families and tribes. The great community could finance large projects of engineering, scholarship, government, and art.

2. Though the Yellow Plain's size and fertility provides great rewards, it also provides the greatest water control challenge of any big river in China. Like the lower Mississippi, the Yellow River traverses much of its plain between levees with the river's surface higher than the surrounding land level. Perhaps the world's greatest challenges in drainage and flood control confront these Chinese people.

Conclusion: Thus it is not too hard to understand that Chinese culture originated as early as it did and as independently as it did because a large set of people developed a taste for rice. The indications are less clear that

analogous tastes or styles not necessary to life itself may have been the emotional basis underlying the technological attempts to harness the great desert rivers which cradled other early civilizations. But after all, nobody had to eat grain or to practice agriculture at all--any more than modern Americans have to undertake extensive fungus or insect culture and therefore enable their population to multiply a hundredfold. Yet taste can hardly be a hereditary trait. It must be culturally transmitted. One who is reared among certain Asian peoples will almost inevitably develop a taste for rice. When I lived among them, I myself developed a discriminatory taste for various rices. On returning to the U.S. I found that none of my neighbors cared about such discrimination. If I talked about it, I bored them, and so I lost some of the taste I had gained. This taste can be important causes of whole civilizations. Surely we need to understand them more. Some methods of exploration come to mind: (1) to allow ourselves to become at least temporarily infected with those foreign tastes and then examine them within us; (2) to review archeology and history with attention to the possible effects of taste; (3) to examine the apparent tastes of peoples in the developing countries and how these tastes change; (4) to examine the development of a taste (a taste prejudice) in young children.

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THE SOCIAL NERVOUS SYSTEM

Colonel Matthew D. Parrish, MC*

Explication of the Psychiatries. Everyone knows that the psychiatry of individuals has a neurological basis. Sensation, decision and action within the individual are mediated by a neuromuscular system.

There is also a psychiatry (sometimes called community psychiatry) which works with the behavioral problems of both individuals and groups by participating in the management of emotional forces among individuals. The community psychiatrist examines the conscious and unconscious social roles and communication methods in the group emotional system which involves the individual. By examining a soldier's behavior in the context of his natural family or unit system, the psychiatrist grasps the meaning of that behavior much better than if the soldier were seen only in the special social system of a hospital ward or the small interpersonal system of an interview room. Management and prognosis becomes more reliable when the psychiatrist deals with entire natural groups.

Styles Guide Scientific Discovery. Community psychiatry can be shown to have a neurological basis just as individual psychiatry can. Up to a few years ago, certain social forces prevented the extension of neurological concepts into sociology. An ever-burning beacon guides scientific thought and sometimes leads it to the truth by very devious and century-consuming ways. That beacon is the assumption that the universe is ordered and harmonious. If a field of possible research looks just too chaotic to investigate today, then scientists will generally avoid it, investigating fields which look more organizable. Scientific thought is also channeled by the popular style of thinking which guides the scientists of any one decade. These contemporary styles or general concepts prevail in many different sciences and arts at the same time, though one science may be unconscious that the same general concept exists in a completely different science. For instance, "field theory" as developed by Maxwell[1] for physics about 1870 had its counterpart in pure mathematics, psychology, economics, and fine arts. Bertalanfly[2] calls these common patterns of thought isomorphies and sees them evolving over time as part of a theory of abstract systems. McLuhan[3] sees our popular concepts biased by the dominant communication media--TV telephone, etc. These media he considers extensions of man's direct bodily gestures.

Neurology, like all other sciences, seems profoundly influenced by the spirit of the times. It is almost impossible to work upon a truly unpopular problem. This paper tries to show how the concepts of neurology have now developed so far that they can become a basis not only for individual psychology but for sociology as well.

The Circuit Concept. Histological techniques and the study of the long tracts of the central nervous systems developed after Faraday, Morse, and Bell had publicized the value of electric circuits and had stimulated intellectual people to enjoy electrical control of apparatus from a distance.

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Anatomists and physiologists fascinated themselves by conceiving the central nervous systems as a set of "circuits". The telegraph line from the toe to the cortex seemed to have only two or three relays in it. It was fascinating. But what about all that tangle of short circuits that made up the reticular formation, that fuzz of nerve cells clinging around the long tracts? And what about all those islands of subcortical gray matter? And what about the glia--those young cells more numerous than the nerve cells they imbed? In those days when it was so "rewarding" to trace out the long tracts, the average investigator would avoid the reticular formation and the glia because they seemed to be just a lot of chaos. Anyone who worked with that garbage would lose his sense of beautiful organization. The circuit men meanwhile looked for a nerve connection between the brain-conscious emotions and their effect on the endocrine system. Ideally, there should have been a nerve connection from brain, through the hypophyseal stalk, to the anterior pituitary--the "controlling gland" of the endocrine system. But they only succeeded in proving that no such connection existed.

Contemporarily, the military was placing a lot of emphasis on getting quick "intelligence" from the forward observers to the headquarters. Societies were interested in quick access to social services or to politicians. They wanted to cut through the "red tape" and obstructionism of local workers and commissioners. Transcontinental express trains and roads thrilled them grandly. In human thinking and living the discriminative epicritic sense seemed more efficient and useful than the gut-grabbing protopathic perceptions.

Humoral Communication. Only when men began to tolerate the relative chaos of tissue chemistry as against clean electric circuitry did they discover the hypophyseal-portal system. It then appeared that the hypothalamus, though a part of the brain, was actually a multi-lobed member of the body's scattered family of endocrine glands. It exerted mutual control on those scattered glands through the secretion of its hormones into a special blood channel directly to the anterior pituitary gland causing that gland in turn to exert hormonal controls over the other glands--again through blood transport of specific hormones.

As emotion, alertness and the protopathic sensations began to intrigue modern science Magoun and others studied the chaotic reticular formation. And in recent years, several bright workers[4, 5, 6] have bitten into the chaos that is the glia. Hyden[5] showed that neurones and their local glia synthesized and stored certain protein when they functioned and learned. Galambos[7] considered that glia were the technicians which programmed the activity of the neurones. The constant movement of certain glia in tissue culture made it easy to think of the glial mass as a great discriminating system of control cells which swished and sucked and pumped active chemicals around--perhaps sensitizing certain clusters of neurones and dulling others. Isomorphic with this view is our special concern with the attitudes of little people, with guerrilla warfare, with military units metastasized among enemy populations, with actions and commitments which are dormant by day in the villages and which come to life at night, or vice versa. Clausewitz[8] considered war itself a sort of international communication occurring when other forms of communication were too vague and incomplete. In today's hot

and cold wars we see this communication not merely between the nominal governments but between the international military and civilian professions--medical, clergy, engineering, police. Among small individuals there is reciprocal help, learning, working, playing, fighting. The boundary between communist and free worlds cuts across frontiers, transects individuals. Any communication is seen as influence, as power. The stationing of thousands of American soldiers in Japan, Korea, Germany, Vietnam, constitutes an influence the Communist powers can't tolerate--quite aside from any fire power. War and the shifting of loyalties and sensitivities is not carried on merely by the main supply routes, the autobahns, the express messages up to the military headquarters or to the emerging nation's president. What once seemed a tangle of small, unimportant, short lived communications now seems to energize emotional and intellectual drives within individuals or among great groups.

Extensions of the Nerve-Hormone System Beyond the Individual Skin Barriers. The stimulus which travels from the retina to the brain did not originate in the retina but rather in the light reflected for example from a pretty picture. Likewise, the efferent impulse which travels from brain to the muscles of hand or foot does not end functionally within the muscles themselves but guides extensions of the human body such as a hammer or an automobile. The channeling of hormones within the individual's body has its social counterpart in pheromones[9] in the insect world. These social hormones are odors released from an insect to attract the opposite sex or to lead other insects to a food source. Pheromones are quite specific in their effect, and most of them stimulate only the intended species. By extension, the effect of the skunk's odor upon his enemies may be said to be a pheromonal effect. In man we find that the axillary apocrine glands grow to giant size at puberty and secrete fluids out onto the axillary hair (which also appears at puberty.) Symbiotic bacteria living on the hair quickly break down the secretions and produce an odor which has a social effect. Before culture superseded so much of biology perhaps this odor attracted the opposite sex. Now with depilation and deodorants the artificial odors become the socially effective ones--perfume, tobacco, incense.

Memory--Individual and Social. There seem to be five degrees of memory: (1) Brief memory (a matter of seconds or minutes) functions very much as if it were suspended in reverberating circuits among the neurones. (2) Longer memory (days or years) seems to be stored only when there is a change in certain proteins within the central nervous system.[10] These changes occur in the glial (control?) cells as well as in the neurones. (3) Still longer memory is stored in the oral tradition prevailing in a group. In this manner ballads and epic poems have been stored. By group conversation, too, events can be more completely recalled. Artiss[11] found, for instance, that he obtained the most accurate and detailed social history concerning a hospitalized patient when he tape-recorded the group conversation of the patient's former barracks mates as they discussed their memories of him. One person's memory would stimulate another person's memory so that the total memory of the group was more than the sum of individual memories obtained from private interviews. Several individual nerve systems interacting with each other could retrieve more memory than the sum of their separate retrievals. (4) Still longer memory is stored in written tradition.

An individual may keep a diary and thereby remember more than he could without it. A nation may maintain a written epic or saga or it may store vast quantities of knowledge in a library. An individual human being maturing in that culture inherits the vast memory of the library. This social inheritance is analogous to his individual inheritance of a fully structured human brain rather than a rabbit brain. (5) More complex, if not longer, memory may be stored and utilized in photos, electronic tapes and computers.

Example of the Functioning of the Social Nervous System. The assimilation of food is an example of neuromuscular social activity. In the mouth a piece of steak is perceived by tongue and jaw muscles; complex feedback circuits are utilized in masticating the food, moving it down the alimentary canal, immersing it in various digestive juices. The presence of the food at a certain station of the alimentary canal stimulates the management of further digestion. But the nervous system's usefulness has extended into the environment from which this beefsteak came. The individual saw it in the supermarket, channeled a small amount of his government's credit into the cash register and took the beefsteak home. The store's loss of the beefsteak stimulated the beef producers to get more beefsteak. Thus, the nervous system of the diner is continuously involved in an economic feedback system which results in his getting adequate food. His economic behavior influences advertisers to influence him through newspaper, television, etc. His nervous system is thus integrated into global economic behavior.

A soldier on guard or patrol uses instruments sensitive in starlight or to body heat to extend and sharpen his night vision. When he is well integrated with the jungle, his alertness changes with the telltale alterations in the noise of insects and animals warning of an intruder. By a tight communication chain across the modalities of smell, gesture, vision and feedback movements among individuals, the soldier uses the scout dog's nose as a supersensitive extension of his own. The soldier's electronically extended voice then regulates artillery fire upon the enemy. The more rounds fired, the more overtime work at the munitions factories. Changes in the particular pattern of artillery fire, however, produce a smaller change in the message communicated between opposing peoples than does a change from the medium of artillery to that of black market dealing, tribute collecting, work supervision, literature dissemination or caring for the sick.

Conclusion. As we organize out of chaos more interconnections among glia, mass media, societies and climates, it becomes less necessary to conceive of a definite threshold or boundary between one part of the nervous system and another or between the nervous system of an individual and its connections into the general social nervous system of his culture. Using such concepts, community psychiatry can see itself dealing with the interwoven relations among individuals, institutions and cultures. It can manipulate and consult upon the appropriate education and communication media, the social memory and ritual, the shifting of roles and influences among cellular and social units.

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Worry is interest paid on trouble before it falls due.
(W.R. INGE)

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MAN-TEAM-ENVIRONMENT SYSTEMS IN VIETNAM

by Matthew D. Parrish, COL, MC*

Here I sit in Long Binh, Viet Nam, on a hot Sunday afternoon. The monsoon is ending and the dust is infiltrating our clothes. It's October 22, 1967, and I've been here about three months, so I'm quite an expert on Viet Nam. By the time I've been here nine months I'll be dumb, and I won't have so much to say. Most people don't, by the time they've been here that long. But, right now, I get the impression that an important thing in the United States is to help all the people of the world get sort of onto their feet so that the whole world progresses fairly well together. In that way, even the smartest and the richest will get along better than if there were too much of a differential between the poorest or the weakest and the strongest. Well, in the United States we find that in getting at the cure to these social problems we have to use some police and military force in this changeover. Now we also use a lot of educational talent and organizational talent that is certainly not police or military. But up to now in Viet Nam it seems to me that we Americans have had to rely a great deal on the military to provide the force and a good deal of the example and of the educational influence as far as Western development goes. I think, too, that we have learned a lot here. I don't think we like to admit it, even individually, that we learned so much, and when we come back to the States I don't think we are able to tell very much of what we have learned because I don't think people in the States are really able to accept what we say as we feel it, and if we are going to be one of you--one of ourselves--in the States, well then, we have to get with <u>your</u> way of seeing things.

We'll tell you something and you'll say, "Oh, I see, you mean like this war is the most nerve-wracking on the troops of all the wars in history?" And then we'll say, "Well, no, not that at all," but after a while, then you'll say, "No, well then, you mean we kill more women and children?" You'll tell us even about details of our personal experiences. You'll tell us what experiences can cause us to drink more, etc. Eventually we end up letting you tell us what we lived through and what we really mean when we tell of it.

We have to let you tell us because if we don't we're sort of deviant; we're not one of you; we are not with the United States; and so the United States has to learn very slowly from the Far East and from other countries, and we can't really accelerate that education any more than we can accelerate the education of a developing country like Viet Nam. Really the slowness is no more on their part than on ours. We have inertia, too. And I don't know how we should learn. I don't think anybody knows. I think we are learning it together, and it takes time to learn it together with a Far Eastern nation. I think we have learned an awful lot since the war with Japan about how to get along in the Far East, how to learn from it.

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It does seem that up to now in Viet Nam the United States Army has been one of the really potent, acculturating forces, and I want to review here something of the way I feel that historically the United States Army has developed and trained individuals and teams and made them into a working and fighting force that does influence, in a most humane and reasonable way, the course of history in our time and especially--I mean here in the developing countries--most especially in the Far East. You see, I really don't think we know we cannot avoid the poor and the underprivileged and their problems in our own country. But it is even harder to avoid for long the total world differential between the rich and the poor, the weak and the strong. For that world difference is so much greater than in the United States

How the U.S. Armed Forces make it possible for a country to change and to progress--even to progress beyond us--is something which requires a realization that in this century the Armed Forces were a lot more to these countries than a mere shoot-'em-up gang or a troop of peace-keeping policemen. The Forces often acted as a set of very individualistic American boys who had lasting personal influence on many peoples the average American hasn't yet heard of. This was especially true with our Special Forces in Southeast Asia. The influence of our medics is deep and lasting. Our military engineers and police also have this sort of influence. The artillery, the bombers, and other technicians who work from a distance are far less important than this. And for all their propaganda usefulness I include radio broadcasters and leaflet droppers among those who work from a distance.

Now, in the Middle East these distance workers are crucial. It is they who win or lose the wars. And because of that, we still emphasize the tanks and artillery as people-scarers rather than the medics, MP's, communications men, etc. as people-knowers.

This is a vast subject. The part of it I'm going into is simply to show the change in our actual training and employment of military men as compared with our traditional beliefs about how we employ them. From now on I might title this talk "The Ultimate Weapon--from Eli Whitney to Vietnam."

Interchangeable Parts as Ultimate Weapons

Now first I'll talk about the problem that Eli Whitney left us. Shortly after the American Revolution the U.S. Army contracted with Eli Whitney, the inventor of the cotton gin, for several thousand rifles. Then one day Mr. Whitney brought in from his foundries the first few rifles for inspection, and I've heard that he poured them out on the table, poured out an assortment of triggers, hammers, and barrels. And the Army representative said, "But these are not finished rifles. Each part has to be filed and worked into a good fit with the other parts, and the whole apparatus has got to be broken in well before it's a dependable rifle." But Eli Whitney said, "No sir, any spring can be assembled with any barrel, any trigger, to make a perfect rifle. All the parts are interchangeable." And so the U.S. Army got started on the concept of the interchangeable part.

The concept worked so well with machinery that it was tried with personnel. Military units set up positions to accord with the formal skills and the roles required. Training schools then attempted to turn out men who met the standards

necessary to fill those positions. For instance, 100 per cent of riflemen met certain standards of marksmanship and fire discipline. The individual soldier with his rifle was said to be the ultimate weapon. It was of primary importance to have highly trained individuals. If a commander had good individual soldiers he had a good unit. But then some strange data turned up. As you know, in World War II only 20 per cent of these well-trained riflemen in combat ever fired a single shot. It seemed that a rifleman in his foxhole, seldom in direct contact with his buddies, feared to run out of ammunition or to reveal his position or to kill somebody. After all, in a firecrackery battle nobody would know if a certain rifle was not fired. But that same soldier, noting that his platoon's machine gun had ceased firing, would holler out to see what the trouble was. The machine gun, with its distinctive sound, was firing not for the machine gunner but for the whole platoon. The stimulus to keep firing came from the group. Now in addition to this, no artillery piece failed to be fired. So we come to the new weapon--a social and mechanical system.

Groups as Weapons

Now these data led many officers concerned with the behavioral sciences to conclude that the ultimate weapon was not an individual, but a group. Seldom does an individual soldier charge the enemy. He does it as a member of a group, with his mind on the group's recognition of him as a member. Even if he parachutes alone at night to blow up a bridge, he feels this group behind him. By putting two men in each foxhole in Viet Nam we have produced a group effect upon rifle firing, and many more individual rifles are fired here than in World War II. But a well-organized group may not be the entire fighting unit. An Air Force crew, for instance, does not like to go into combat with an aircraft it has not checked over well and flown before. The ultimate weapon there is the wedding of mechanical hardware with a well-integrated social group, a system composed of aircraft, crew, and to some extent, the maintenance institution and the navigation aids on the ground.

Strategic Air Crews

Now let's take the example of the aircrew. The aircraft with crew, as an entity here, is prepared to carry out missions almost anywhere in the world. The crew of a B-52 works much the same and feels much the same in a mission over the Arctic or over the Andes. It lives at the same cabin temperature and eats the same in-flight food. It carries its environment with it. Today, B-52 fliers tell their children good-bye on Guam and they fly to Viet Nam. Sometimes they do not even see the ground under them in Viet Nam. Their mission successfully completed, they return for a midnight snack with their wives on Guam. Now aircrews function more expertly if the crew is kept intact when it's moved to new stations around the world. If a crew is dispersed to form completely new crews, then these new crews, though they are composed of experienced individuals, go through a breaking-in period before they become as proficient as the original crew. The unit which does the air fighting is a crew familiar with its own abilities and feelings, and experienced with a certain aircraft in which it fights. It then becomes skilled in bombing certain targets. The aircraft becomes an extension of the bodies of the men, and the men are organs functioning in this system. The flight instruments are extensions of the pilot's labyrinthine system, the semicircular canals, and so on. The radio is an extension of

the pilot's ears, and the radar and some other instruments are extensions of his eyes and also of the navigator's eyes. The navigator's eyes coordinate with those of the pilot. The tail gunner's eyes, the tail gunner's muscles, coordinate by means of electronic communication with the ailerons and the control surfaces of the aircraft, actually through the pilot and his instruments and the machinery of the aircraft.

Now this crew doesn't have to live in the environment of its target. It only lives with the airplane, and the atmosphere, and its base. The machine modifies the crew, and the crew modifies the machine. It's more than adaptation. A crew which merely adapts to its machine environment is only a slave to that environment. The alert and lively crew gets with its environment. It makes innovations, improves methods of crew operation or of machine structures. Now, of course, there are many different ways of life among the man-crew machine systems in the Air Force, and some of these systems approach pretty closely the qualities which we find here among infantry units, but right now I am sort of polarizing the aircrews in order to delineate the modern way of living here a little better. So I'm talking mostly about Strategic Air Force crews and really, sort of one aspect of them.

Surgical Teams

Now let's go to the example of the Viet Nam surgical team. The development of surgical teams here is an example of a group's making its environment and its mission a part of its own formative growth, a creation of a new kind of group out of the interplay among trained individuals, their mission, and their environment--just like the Air Force crew. It's virtually impossible to send to Viet Nam a new surgical team which can, from the date of arrival, practice with the same skill as a team which has been in Viet Nam a few weeks. Now, what would face such a team, trained in the best U.S. surgical center and well-practiced as a group upon the available aspects of general surgery? Getting halfway around the world to a tropical climate would knock loose a few of that team's diurnal physiological rhythms. The group would tend to get sleepy at the wrong time, and so on. Personally, they'd have to adjust to the heat, the dust, humidity, and these cataracts of sky water that crash upon us. They'd have to adjust to family separation and the night-long shudder of their buildings from artillery.

Professionally, they face several problems the like of which are never seen in U.S. training centers. First of all, they face a strange, emotional atmosphere. Any team handles well a case brought into its routine operating theater when that team is prepared. The team follows all the principles it has learned. But put the team in a radically different theater with a new sense of urgency, a new emotional climate, and then it no longer acts as if it knows. After the Worcester tornado in Massachusetts there were some 350 major contaminated wounds handled by competent surgeons who had often taught others never to suture contaminated wounds, but these surgeons are reported to have worked heroically all night long, suturing 350 contaminated wounds. Now this is by no means peculiar to Massachusetts or to mass casualty situations. It happens to some degree in civilian or military practice wherever teams are working in a completely strange atmosphere. An individual or a team acts as if it had different training when it works under different environmental conditions--perhaps in isolation from familiar cues and with the senses flooded with new climatic, linguistic, or mechanical surroundings.

Now, the second problem they face is high-velocity wounds. Wounds inflicted in Viet Nam often require more extensive debridement than wounds of other wars, much less the low-velocity gunshot wounds that one sees in the city hospitals in the United States. Viet Nam wounds are very deceptive to the surgical team which has not worked with them before.

The third problem is severe wounds. A helicopter, minutes from an ambush, may set down beside the operating room a patient with high traumatic amputation of both thighs. He is still alive. Such patients in the United States practically never reach the operating table but here you have them on your hands.

The fourth problem is mass casualty. A 400-bed hospital here may admit forty or eighty extreme emergencies in an hour, and this happens not just once a year but any old time. Does it do that in Walter Reed now? Do they do it in Boston City Hospital?

The fifth problem they have here is simultaneous surgery of multiple body systems. I mean by that, a single patient, still alive, may present severe wounds of head, chest, abdomen, and extremities--one patient. The question arises: how many surgical teams can work on the same patient simultaneously, and how long should a team work on one part of a patient before some other part then assumes a higher priority? How often does that question arise in Walter Reed?

Sixth, there is a new hierarchy of medical communication and transportation. Not only does a chest wound affect the priority of extremity wounds in a single patient, but it is rapidly coming to the point here that every new wound on the battlefield, the minute it occurs, changes the priority of every other wound in the whole country. If several moderate wounds are awaiting treatment at the nearest surgical station, then a more urgent wound may be programmed in ahead of them, or it may be evacuated to a more distant station with a clear operating room. Because of air ambulances and on-the-spot medical regulators with a radio, the surgeon feels himself a part of a well-oiled, country-wide machinery. He is not just a private doctor of a single patient, though he does remain that also.

As far as the history of trauma surgery is concerned, the surgical team in Viet Nam lives on the edge of tomorrow. Civilian pickup and management of traffic injuries in the United States have not yet caught up with the military's former management of patient flow in Korea, much less in Viet Nam. In all history, there has never been a school of surgery to equal Viet Nam, but this school does not train mere individuals. It trains teams within their environment. The well-trained U.S. team arriving in Viet Nam to work finds its post-operative morbidity very high. This happens. This is not theory. After two or three weeks of intense practice, this morbidity drops to the level of other teams already experienced in Viet Nam surgery. A surgical week in Viet Nam contains a month of experience. Thus, a team which is most expert in the surgical problems of Viet Nam comes into being only in Viet Nam. It is an integral part of the climate and the medical environment here. Accordingly, it's no longer usual to install intact any new surgical teams from the U.S. The Army in Viet Nam substitutes new members, one by one, into teams already practicing well in Viet Nam. The integration of a new member, say a scrub nurse or a surgeon, does cause tenseness and some over-alertness in the team, but it does not significantly affect patient morbidity. This team in its environment captures the new

member and forces him to get with it. In a week the team is as smooth and relaxed as it ever was, with even the most challenging surgery. This capture of a member cannot be effected by reading or by lectures. There's a whole social and environmental atmosphere to be absorbed. One gets the hang of it. One does not merely analyze it intellectually. So it is that members come and members go, but the team in its environment keeps on developing and improving.

The Infantry Unit

Now let's talk about the example of the Viet Nam infantry unit. Any group welds itself into an effective team in the playing fields where its big games take place. The experienced, strategic aircrew is all set to operate against any target in the world without further adaptation. Its field of action is the entire stratosphere, which differs but little in the various parts of the world and exposes the crew to few physiological adaptations beyond those that are learned in normal training. The aerial man-crew-machine system remains intact and constant, while it affects the target distance from itself. Similarly, the experienced Viet Nam surgical team is a functioning organ in a coordinated country-wide organization of medical management. It's set to handle any wounds in the country. So, Vietnam is its stratosphere, so to speak.

Now the Viet Nam infantry unit, however, with its accompanying medics, reaches final maturity only while infused into its own target area. This team, in its environment, handles new recruits, visitors from the U.S., and the enemy as outsiders needing to be changed. Even Charlie is not necessarily shot or captured. He might be converted to our side right there in the village without the team's being sure he ever was a true enemy. The jungle infantry team is symbiotic with the jungle. Its individual soldiers coordinate quickly with each other in their response to communication with natives, to a change of jungle and village smells and sounds, or to the reactions of their dog and his handler. The jungle fighting group gets with its jungle environment in a manner analogous to the aircrews getting with the aircraft. The jungle becomes an extension of the men's, of the team's organs of sense and locomotion, and the team becomes an extension of the jungle.

Now let me give you a generalized example of how infantry training and experience may develop. First, in the U.S. an infantry brigade is put together from men trained in various basic and advanced schools. Many of them have seen combat in various theaters. These men maneuver and practice as a team until they are familiar, trusting, and nicely coordinated with each other. They study and do exercises in tunnel warfare, night infiltration, special fire discipline needed for Viet Nam. They learn all about mines, punji sticks, booby traps, ambushes, enemy ruses, all this in the United States. The brigade has become a team. It deploys now in forested plains, north of Saigon. There one of the soldiers, who knows all about booby traps, finds a cigarette lighter and it blows his hand off. His buddies, also trained in such matters, rush to his aid and a Claymore mine kills five of them. All right, a soldier jumps across a ditch and onto a set of punji sticks under the leaves. A little girl walks in among the Americans in their camp. She is carrying a satchel charge. A company completely surrounds a village and fights its way in, but it finds only women and children. The Viet Cong has escaped by a tunnel or a little string of

underbrush. Farmers, seemingly on freedom's side by day, are VC by night. All of this the brigade already learned in the U.S. but they learn much of it again the hard way. By now the brigade has a way of absolutely convincing any replacement how to behave. By letting peers and comrades teach and acculturate each other it surrounds the new man with a very cohesive group and it forces him to get with it, thus making him very hard to kill.

Having learned well and having cleaned up the plains, it moves confidently to the central highlands. There the weather is colder, wetter; the malaria is of a far more deadly type. The natives are mostly Montagnard, with ways of living and thinking completely different from the majority of Vietnamese. The enemy is not the VC but mostly the North Vietnamese regular army. There are few booby traps or tunnels. Many of the things the brigade is alert to no longer apply. One day an American company is following down a steep mountain trail. The platoons are fairly well spread out in a manner okay for the southern plains. Suddenly, in the thick woods, a North Vietnamese force fires into them. The Americans can't concentrate their platoons. The second company is too far back to move up through the mountanous forest. Air support is called in but the individual Americans have insufficient markers to show their position in this terrain. They're pinned down by their own air fire. Reinforcements come but this enemy does not evaporate as the VC would. The Americans simply aren't with it yet in the central mountains. A few weeks later we find these same Americans traveling in different formation, alert to different clues, carrying more ammunition and more air signals. The NVA is getting hard to find. The brigade has begun to take over this terrain. They've become a part of it. Newcomers are now trained differently but no less coercively. They are trained into this brigade, for these mountains, and to this enemy. As this man-team-environment system they exist only once. If the brigade is now moved to the Delta they begin a new system, a third system. They forge a different weapon.

Concepts and Training

Now let's talk about how the weapon is forged. I mean the weapon for war or for work. The concept of the team in its environment as the ultimate weapon is still in process of formation in Viet Nam. These weapon systems have developed slowly and have not dramatically taken us away from some residual adherence to Eli Whitney's interchangeable part principle nor from the myth that a good ground unit from a big U.S. center can immediately fight efficiently in any terrain. Of course, a dramatic demonstration of the need for new concepts would occur if the ground team's change of fighting terrain were great enough and quick enough.

Assuming the concepts we've been talking about are correct, what would we expect if a unit of highly trained airborne troops were moved from some southern U.S. training center and put into a Himalayan pass tomorrow? Let's put them in the saddle of Karakoram pass, 18,000 feet above sea level, not on the heights above the pass; now, that's higher. Half the atmosphere is below them. All right, we'd expect this fierce team to become weak, dizzy, nauseated, slaphappy, and without ability to use good judgment, facing the cold, the lack of oxygen, the rugged mountain walls. A month of training on Pike's Peak would acclimate them better to altitude. A month or two in the Karakorams and these mountains could become a part of them. Now once a team is established and matured

in its fighting environment it can keep up its strength and skill by staggered personnel rotation and periodic visits with inspectors, consultants, higher staff, and the enemy, all of whom teach and learn. But the team usually cannot be moved intact to a completely different sort of environment and perform immediately with the same behavioral characteristics. The situation in Vietnam has required us to break up new teams entering the country and to infuse their members into units already symbiotic with their environment.

Now let's talk about the lesson for military trainers in this. First, the individual soldier still needs his body and mind trained in strength, skill, and knowledge. But the training groups which bring about this individual advancement in the States are already amazingly competent--basic training, artillery training, and so on.

Second, the trained individual is not instantly interchangeable among units. He needs that informal polishing from friction with his team members he is to work with. The time required for an individual to become an organ of the group, and the group a part of his now greater self, varies with the kind of task the group faces. Just as on maneuvers in the U.S., an Army team jells more quickly than it does in garrison or school; so in Vietnam, with its no-fooling urgency of cooperation and its lack of irrelevant distractions, the team jells more quickly around its task and its environment than it does in the U.S.

Third, the unit cannot be efficient in its task until it has infused itself properly into its working environment--the strategic air crew into its aircraft and its stratosphere; the surgical team into its climate and flow of patient types; the infantry unit into its terrain, climate and friendly and enemy cultural traits. The trainer must help men and units so to adapt.

Methods of Training

Now, let's examine the characteristics of training. It seems that NCO's and officers in formal teaching roles carry out 90% of the school training in the U.S. They do it in three ways: by lectures, by demonstrations, and by practice under supervision. But in Vietnam a fourth way becomes prominent. Every man, as he gains experience, becomes himself an informal teacher to his own peers. Thus, by lecture, a formal teacher tells the men how to use the rifle. By demonstration, he field strips the rifle in front of the men, assumes proper firing stances, and so forth. By supervised practice, he coaches the men as they field strip the rifle, and fire on the ranges. But in Vietnam the men informally teach each other with considerably more urgency than in the United States. This last sort of teaching determines what part of their former training the men adhere to and which they abandon. It forces the men to take their places in the particular man-team environment system. This happens to the surgical team; this happens to the air crew; this happens to the infantry.

All right now, to summarize all this: Three concepts of training in the employment of units as work forces or weapons have developed in sequence during U.S. military history...each concept partially supplanting its predecessor. First, the ultimate weapon is an individual soldier, trained as an expert to fill a certain slot for his MOS within a unit. The fallacy here: "The unit or team is ready for combat when all its slots are filled with these trained and interchangeable individuals."

Second, the ultimate weapon is a group of men trained by working at a common task long enough to set up informal connections of trust, understanding, and coordination among the individuals and thus to form a team. If such individuals are pooled and reshuffled into new units each unit will again require time to form itself into a team. The individuals are not immediately interchangeable. Now, the fallacy here: "The team, however, is ready for combat or work anywhere in the world, upon any task it has been trained for."

All right, third, the ultimate weapon is a symbiotic system of trained individuals forming a team infused and acclimated with its working environment so that the environment is used as an extension of the team's sensory and motor apparatus, and the team is able to employ itself as an extension of the environment. A team cannot move to a completely new environment and immediately function well.

A bomber crew moving to a sister ship takes a little time to get with the new bomber. Moving to a completely different type of bomber takes a much longer time. But once a strategic, man-crew-bomber system is well set up it can bomb any target on earth. A surgical team involves itself with the environment's particular climate, community culture, diseases, instrumentalities of trauma. Such a team may move from one Vietnam hospital to another without losing efficiency, but it can't move from the U.S. to Vietnam without taking time to develop into a different team-environment system. It probably couldn't move from Vietnam to, say, the Middle East, either, without taking time to develop into a different team-environment system. Once a surgical man-team-environment system is well set up in Vietnam it can practice anywhere in the country. An infantry team acclimated to jungle operations, however, cannot be moved to the Delta and be expected to fight efficiently until it has worked itself into a symbiotic adjustment with the Delta. So, once an ultimate weapons system (man-team-environment) has been formed it can maintain itself at peak efficiency by infusing individuals in and out of the system, a few at a time. Its natural growth and development will be continuous, but drastic and sudden changes of environment or personnel temporarily reverts the system to a sort of embryonic stage and it may cause a different system to arise.

In World War II it was often conceived that the group behavioral characteristics of a unit were maintained or improved by men who had remained years with the unit and did not expect to leave it soon. These men were the unit's memory and historical stability. In Vietnam, with its one-year rotation for each soldier, the unit with its environment maintains--just as the nation does--a total developmental history and a group attitude quite outside the memory and experience of any individual member. The individual partakes of the personality of the unit's environment system when he arrives in it. A particular individual may feel his year with a Vietnam unit was an episode discontinuous with his life in the tailor shop back in Brooklyn, but the unit usually feels that he contributed smoothly to the continuous development of the unit environment system. In Vietnam, the ground forces are developing man-team-environment systems, the ultimate weapons for work or war. These systems cannot exist as such outside Vietnam. Some infantry systems cannot exist as such outside a particular region of Vietnam. If the teams or the individuals are taken out of Vietnam some of their skill may be transferable to other combat situations, and if overconfidence does not ensue, the time for developing a new system will be shortened. Now, that's the most we can expect, but considering how much the team in its environment can teach the rest of us, that's quite a lot.

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By Matthew D. Parrish, MD

THE NOMAD AND THE CULTIVATOR

Comments on "The Frontier in History", P. 469 in
STUDIES IN FRONTIER HISTORY BY OWEN LATTIMORE
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Dialectic

It is common for most of us to conceive of new ideas as developing out of an interface between two individuals who oppose each other as intellectual adversaries. Quite aside from any particular individuals, new ideas may develop out of the opposition of two ideas in dialectical fashion. That is, one idea called the thesis is opposed by a contrary idea called the antithesis. The interaction of these ideas and the arguments piled up on both sides produces a final conclusion which has a greater amount of truth in it than either the thesis or the antithesis. Sometimes too, a father and mother who take different positions with regard to the rearing of children may help the family to be a better child rearer.

International Dialectic

When I considered all the corrections and creativity that could arise from the interfacing of two different people or ideas, I considered that much creative work should come out of the frontiers between nations, and I thought I saw evidence for this in the creative work in chemistry which arose in Alsace in the nineteenth century during a time when Alsace was uncertain as to whether it was going to be a German or a French province. Alsace originated ideas for the artificial fixation of nitrogen and the synthesis of the Red Dye, Madder. Robert Burns spent much of his life in the border counties of Scotland. Wordsworth wrote some of his best works in the marches between England and Wales.

At other times, however, it seemed to me that while ideas may have originated in some province, they were further developed and condensed in a central, cultural crossroads or capital. Following this, capitals faced each other; thus, Paris' ideas might face Berlin's ideas, and nothing relevant to those ideas might ever be solved in the Rhineland.

East Asian Frontier Dialectic

Owen Lattimore, in his twenties, probably explored the frontiers between China, Russia and India better than any other western man. He and his fiancee traveled extensively over those lands, and furthermore, he was fluent in some of the prevailing languages. It seemed to me that he bacame influenced by ideas which were foreign to the usual way of thinking here in America. We citizens, however, instead of interacting with Lattimore's unusual ideas in a dialectical fashion so as to improve our own understanding, labeled him during the McCarthy terror as "not one of us". He was greatly criticized and expelled from political office so that the United States lost the possible services of a man with ideas beyond those we, ourselves, could grasp at the moment. What follows here is my own version of some of Lattimore's ideas about history.

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Lattimore on the Herdsman and the Farmer

The usual economic progression is not from hunter, to shepherd, to farmer, to urbanite. The true shepherd nomad developed only with the horse, which did not reach China until

after 300 B.C.. Some of the Chinese who had been cultivators more than a millenium then took to shepherding.

The non-nomadic shepherd developed out of agriculture when rain became scarce. He usually combined grazing with grain production.

Truly primitive societies are undifferentiated as to means of living. They eat anything they can pick up, or catch--at least it seems that way to an urban observer. The primitive people require a wide range of land for each individual. Pastoral nomadism, however, supports larger social units, especially if the units are on the move. Rainfall agriculture can go even further, and can support villages and towns. Irrigation can support cities. A commercial network of towns supported the Renaissance and Baroque eras in Europe; factory economy supported Europe after 1800. The corporate planning system supported the economies of the developed countries after 1940 and "exploited" the "undeveloped" countries.

Any country tends to transmit distantly its own traditional way of living. China tried to spread agricultural economy. Beyond the Wall, agriculture had to become largely animal husbandry, for water was scarcer out there and non-Chinese tribesmen more plentiful. Southward, however, the Chinese merely pushed into the low lands like a slow flood. The indigenous people (now Montagnards), moved to higher altitudes and were surrounded by these Chinese farmers below them.

Indigenous tribes became weak, but their chiefs became stronger among them as they faced peoples with a higher economy. The chief is the tribe's contact with the larger culture which presses upon it. The large foreign culture actually strengthens the chief so that the large culture can deal with the indigenous society as a unit through that chief. This situation obtains (consciously or unconsciously) between the U.S. and the governments of developing countries. We deplore the lack of democracy in those countries while our prestigious communication forces more power upon any king or dictator they may have.

China was most threatened by nomads because:

1. The mounted archer was more mobile than China's boots and wagons, and poured great fire power upon them.

2. China's great cities sat still for the nomads to make swift conquests of them.

3. The nomads could dodge and scurry their wealth out of China's reach.

The people living close on each side of a frontier sometimes form a common "country" against the distant power centers of their respective nations. The frontier peoples, for instance, are interested in smuggling, while the capitals of both sides hate smuggling. Thus, the frontier becomes to some extent, a separate nation within itself so that the foreigners along the frontier have more in common with them than the people of their own capital.

(P. 481n) After 400 A.D., Priscus, a Roman historian reported that a Greek merchant captured as a slave by one of Attila's chiefs bought his own freedom with his soldier-won-booty, but remained attached to the same Barbarian chief. He was more comfortable there than he had been as a prosperous merchant in Dalmatia. In war-time Dalmatia, he would have died because of the incompetence of Roman military leaders and bureaucrats. In peace-time, Dalmatia he would face high taxes and poor police control of powerful criminals. Priscus' rebuttal against the soldier was only in terms of philosophy, not of

life satisfactions. He said the constitution of Rome was very good; professions were well developed, etc... This argument is similar to the argument a Mandarian might give concerning a Chinese soldier who went over to the nomads.

Trade in Europe before the renaissance did not proceed by any mercantile theory. Rather, it was rich gift trade between nobles, often in the form of tribute, with special bargains made on the side. Trade was based on "whom you know" and not on a free market. Consequently, interruption of trade was not an economic cause for war as it is in the modern states. J. B. Bury and other historians who see economics as a cause for war in certain ancient times were really trying to project their own economic notions onto inappropriate countries and times.

THE MEGAHOSPITAL DURING THE TET OFFENSIVE

COL Matthew D. Harrish, MC*

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Vietnam is a megahospital[1]. The condition of every bed and every doctor affects every other. This paper will deal with the Army service within that megahospital. Data from other services would be misleading if compared directly with the Army since medical missions and policies differ. The present discussion is based on a review of official observations by Army medical commanders and administrators upon the TET offensive. Descriptions are of facilities as of January - February 1968.

STRUCTURE OF THE ARMY TREATMENT FACILITIES

Each combat division had its own organic aid stations and clearing stations which carried on essentially emergency and triage work. Clearing stations were capable of holding for a day or so on emergency cots some 2,500 mildly injured patients. By keeping patients on litters this number could theoretically be increased by 1,250 patients. Though it was not unusual for certain patients to remain three days in a Division Base Camp medical facility before returning to duty, still most of these mildly affected patients would be discharged within 24 hours. These facilities normally kept hospitals from being flooded by minor surgery and mild diseases.

Outside the organic structure of the combat units the country wide hospital and dispensary complex of the 44th Medical Brigade contained the following hospitals:

5 Surgical Hospitals totaling	300 beds
8 Evacuation Hospitals totaling	3,200 beds
3 Field Hospitals totaling	805 beds
Total operating beds	4,305 beds

In addition there was a convalescent center with 1,300 beds authorized for patients requiring minimal professional care.

From experience in former wars Surgical Hospitals were devised as mobile facilities close to the division rear clearing station to provide mainly resuscitant care. They rendered patients transportable to larger hospitals. Evacuation Hospitals provided definitive care and also prepared patients for further evacuation to general hospitals in the communications zone or CONUS for definitive care. In RVN there is no communications zone and the available hospitals have tended to take on the function of station hospitals supporting an area.

THE TET OFFENSIVE

The Communists began their celebration of TET by an offensive on 29 Jan-

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uary and by the first hours of 31 January the attacks were in full swing all over the country. For a day or so then all but two air bases in RVN were closed. By 4 February the big influx of casualties had subsided and supplies were beginning to flow normally again. Some rather intensive mop up fighting continued during the month of February.

THE RELOCATED EVACUATIONS WITHIN THE 95TH HOSPITAL

1. The beds available.

The average of 53% bed occupancy was an ideal margin to work with when the airfields were closed. The opening of airfields allowing for offshore evacuation gave marked relief to accommodate future patient loads.

The press of a massive emergency is no time to sort out and transfer the patients who should have gone to the convalescent center or to general hospitals out-of-country. As long as the possibility of such massive influx remains, hospitals bed level should be kept low in RVN.

2. Mascal plans.

Each hospitals as it was put originally in service formulated mass casualty flow plans and methods of platooning hospital staff so that uninterrupted 24 hours intensive service could be carried on indefinitely. Yet it was only after each hospital had undergone several mass casualty emergencies that staff began to adhere efficiently to the plans. As a mass casualty operation begins an inexperienced hospital tends to allow all members of its staff to assume devoted curiosity and self application to the drama as it unfolds.. Twenty-four hours later the entire staff is exhausted, judgement and efficiency are lowered, but the mass casualty flow continues. Before TET other mass casualties had fortunately drilled most of these dangerous tendencies out of RVN medical staffs. Nevertheless those hospitals fared best though the six day emergency which insisted on disciplined platooning from the first moment of the attack.

A hospital has to learn by prolonged drills or actual mass casualties how to make a staff platooning and a casualty flow plan work in that particular hospital. Hospitals all over the world which have not had such experience should seriously question their own ability to handle a prolonged mass influx of seriously wounded which cannot readily be evacuated.

3. Interchange of professional talent.

Doctors assigned to combat units which were not heavily engaged were temporarily released under centralized control for optimal utilization elsewhere. This brought considerable relief to more hard pressed installations.

Centralized control of medical talent within divisions and within the 44th Medical Brigade releases the medical service to concentrate economically upon medical problems wherever they arise.

4. Regulation of the patient flow into the hospitals was managed by a radio network which sent a certain patient to a certain hospital after matching his type and severity of wounds with the type of surgical capability and backlog present at the hospital. Experience a year earlier had shown that the regulation of patient flow by means only of beds available in each hospital overworked some hospitals and spared others.

The crucial factors in medical regulating are:

a. Dependability and accuracy of professional and ancillary communication.

b. Availability of professional personnel.

c. Availability of operating facilities and supplies.

To improvise beds is sometimes possible. To improvise surgeons at operating rooms is a different matter. Many patients with minor wounds bypassed forward clearing elements and went directly to large hospitals unnecessarily increasing workload. Especially when casualties are heavy, minor wounds should be treated in forward areas and quickly returned to duty leaving the hospitals free for work that only hospitals can do.

5. Air transportation.

The poor roads in Vietnam, the enemy's scattered presence and the slowness of convoys have resulted in patient movement almost exclusively by air. With the airfields closed during TET, patients could not be moved except in helicopters.

Adequate supply stocks should be maintained locally and the proper reordering never put off. Some maintenance for ground movement of patients should be considered.

6. Communication.

A crucial part of the medical regulating radio net had been established six or eight months before by employing civilian type single side band radios. Although overloading and destruction of phone lines disrupted so much administrative work, medical regulating remained unaffected.

Single side band radios proved essential for an adequate medical regulating net.

7. Attacks on medical facilities.

The enemy did not spare the shelling of medical facilities. Many patients and staff members owe their lives to good sandbagging. Some supplies were lost and damage done, however, which would have been lessened if there had been more sandbagging and bunkering. One dispensary with insufficient emer-

gency power had to care for patients by flashlight during an attack.

Medical facilities (including vehicles and dustoff helicopters should be bunkered, dispersed and revetted. In times of quiet, emergency power supplies should be tested for adequacy.

8. Civilian labor.

During the most active days of the attack there was more need than ever to utilize the great number of indigenous civilian personnel who have been integrated into military hospital work. But this labor was almost totally absent. Very few of these civilian workers were present for laundry, kitchen, custodial, or clerical work. Valuable military technicians were tied down to KP etc. and were working almost around the clock.

Loss of crucial labor is certain to recur at any big attack unless key civilians are quartered within the compound, their villages better protected or "civilization" discontinued.

9. Civilian casualties.

Large numbers of civilian casualties complicated the care of military patients. Civilian casualties become particularly difficult to fit into the routine military patient management because:

a. They can't be identified nor followed easily.

b. The staff doesn't usually speak the patient's language.

c. Neither the Vietnamese nor the Americans have a social work service adequate to keep patient and community properly cooperating and communicating.

d. Patients were not familiar with western sanitation practices and medical procedures.

Contingency plans for coordinate management of a flood of civilian patients should be rehearsed with Vietnamese civilian and military authorities in all major populated areas. For example means for temporary shelter, food, water and sanitation could be allocated with real estate and alternate sites designated.

10. Psychiatric management.

In the press of mass evacuation psychiatric patients were often loaded on the same helicopters with the severely wounded and were evacuated to hospitals, thus bypassing their normal psychiatric support. This procedure tripled the proportion of patients eventually evacuated out-of-country in divisions where it was allowed to happen.

When a hospital receives psychiatric patients who have bypassed their division or other normal psychiatric support, it should as a rule evacuate them "retrograde" to their unit's first echelon psychiatric facility. The crucial principle in management of most psychiatric problems is to keep the patient and his unit closely identified with each other as the problem is worked out by psychiatrist, patient and the unit. Evacuation to a distant hospital makes impossible the natural resolution of many problems.

DISCUSSION: THE "LESSONS LEARNED".

Few things learned are really new. Most general principles have been discovered in other years or centuries. But some well known principles oppose other well known principles. For instance the principle of keeping a large fraction of hospital beds free for mass casualties opposes most economical use of beds in normal days. Keeping lightly impaired men within the division area and returning them quickly to useful duty without loss of personal commitment to their units opposes the principle of centralized medical care which is most conserving of medical personnel and material.

Perhaps one of the most lasting principles, however, is the attitude of searching skepticism and continual reevaluation one finds in the megahospital. Just as a U.S. teaching hospital reevaluates its clinical acumen with pathology reports and clinico-pathological conferences, so the RVN megahospital continuously evaluates the effects of its current techniques and policies.

Certain natural breaks in communication still impede the complete integration of all the facilities caring for RVN casualties. One rarely heard doctors in Japan or CONUS complaining that certain patients they receive should have been managed differently, e.g. perhaps a certain patient should have remained in RVN or others should have received a different treatment there. Understanding is somewhat improved by the visits of consultants, by conference between offshore and in-country professionals, by intertheater transfers or calculated assignment of certain RVN returnees in U.S. teaching or administrative centers.

Nevertheless the dialectical professional evaluation of the global free world military medical system doesn't appear to approach the rapid and close integration of experience which has developed so far in the Army's RVN megahospital.

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THE COMING UNITARY LIFE

An Interpretation of Unitary Man
With Special Reference to L. L. Whyte

-M.D. Parrish

What is a Unitary Person:

There seem to be two ways of presenting modern-day concepts of how individuals live and think. On the one hand people like Ayn Rand[1], Erik Erikson[2], Erich Fromm[3], and many existentialists believe the individual is autonomous and makes his own personal decisions quite distinctly from the thinking processes of any other individual. His early life consists of a search for a solid and unique identity--a distinctiveness from all other persons. One aim of psychotherapy then is to help the individual find such an identity. Most such psychotherapy assumes that once a person has a good solid identity, he will keep it in spite of shocking changes in the world around him.

On the other hand, Alan Watts[4], Erwin Schroedinger[5] and many students of Zen or of Indian philosophy maintain that no one can perform a purely spontaneous act. External forces always influence an individual's behavior and thought. This second philosophy is often unpopular today because people think it encourages the individual to feel he is only a "company man" who belongs to the corporation and must think corporate capitalistic thoughts or collective communist thoughts.

In some eras of history, e.g. medieval, men have unified these two ways of thinking and have become able to live and think in tune with both. On the other hand, in some eras, e.g. renaissance, people have teased apart these ways and have selected one or the other. Perhaps we could call this one-sided person the half-man. Today it appears that the unifying people are again becoming prominent--people who can integrate these two different natures into a single balanced life. Lancelot Law Whyte[6] called this integrated sort of person "unitary man".

The Teasing Apart of the Individual and His World

From a sociological point of view the society secretes the individual. He is formed out of the already existing society. Without the language which his society teaches him, he probably could not solve any abstract problem. From the individual's own psychological point of view however he excretes the world of nature and society from himself as an individual. He senses that as he grows up he forms more and more of his own perceptions and feelings about the qualities of the world around him. He has become independent, autonomous. He has excreted the world and now sees himself as an observer who looks at that world from an arm's length. The "sociological" type of individual however sees himself as an inseparable part of nature itself. Observing himself, he must observe nature.

Scientists who study governments and microbes from a distance often conclude that we ourselves are disconnected from the processes we observe in trees, stars and Navajos. We split ourselves apart from these objects of our thoughts as if we ourselves were quite separate objects. We certainly do not conceive that in observing Mars we are observing part of ourself.

We have carried this divisive kind of thought so far that in some forms of

psychotherapy the client as a thinker steps eventually outside of the living person which is his self and figures out the qualities and tendencies of that person he is. He steps outside his own childhood and deals with it as if it were a separate life from his present life.

Some scientists, however, as they study more closely the stars or "primitive tribes" come to believe that these things are not entirely separate from the scientists themselves. The same laws which seem to regulate stars and atoms also seem to regulate the bio-chemistry and neurology of the scientist himself and of his society. These laws determine the way he and his society must think.

The psychiatrist who never leaves the middle-class life of modern cities usually thinks of the scantily clad aborigines of the Amazon forests or the Australian Outback as "primitive". He sees aborigines as maintaining a childish life and thought, something like the childish behavior the psychiatrist himself experienced when he was four or ten years old. In this respect the psychiatrist doubts that the aboriginal is participating in the same adult life process which the psychiatrist participates in.

The anthropologist however who goes to the Amazon or to the Outback and becomes a part of these societies almost never considers them simply childish or primitive. Levi-Strauss[7], for instance, finds that the aboriginal has just as large a working vocabulary as a Philadelphia lawyer and he has just as many procedures and customs to learn in order to get through a day in his own environment. Instead of remembering interest rates, office procedures and courtship rituals for the cocktail lounge, the aboriginal will have to remember hundreds of poisonous and non-poisonous plants, dozen of procedures for propitiating the forces of nature and a complex of tribal courtship rituals.

Now Lancelot Law Whyte[6], as I understand him, thinks a bit like the anthropologist. He has considerable respect for the "unitary" type of thinking which developed in certain periods of history and which kept the thinking-person-as-subject integrated into the thought-about object. Such thought was little concerned with the great dichotomies of good and bad, guilt and innocence, free-will and determinism, mind and body, etc. Whyte has an equal respect never-the-less for the "dualistic" type of thinking characteristic particularly of the Greeks after Plato and of Europe after the Renaissance.

Such dualistic thought is less appropriate in the twentieth century than it was in the Renaissance. Modern European man has turned toward his own version of unitarian thought which derives something from his medieval past and something from the unitary sort of thinking found today in Asia and Africa.

For Whyte the memory with an individual brain is analogous to the written or architectured records of the social past. The sensory and motor functions of the nervous system are analogous to the contemporary perception and action of a total society as it meets its immediate challenges from the environment. An organism such as a human person, an industrial corporation, or the total culture of a coherent people maintains a balance between these records of the past on the one hand and the ever-developing management of the present challenges on the other. When the past records and the present development operate so that each connects to the other and continually influences the other, they are hardly seen as separate entities. For certain periods of its

history however a person or a society will emphasize a dualism between, on the one hand, the seeming truths and certainties of records, mathematical systems and fixed philosophies, and on the other hand, the continual "political", artistic, or innovative wheeling and dealing with ever-changing events and problems.

An example of the use of a recorded system of philosophy to manage present-day economic problems is the government's use of Keynesian economic theory in order to control inflation and to prevent economic depressions. In the 1930's John Maynard Keynes[8] devised a way for large government to prevent economic booms and busts by entering the national market system by means of government spending and the regulation of taxes, interest rates, wages and prices. The Keynesian system largely amounted to a formula--a set of economic truths from which a government could select appropriate actions to fill any current economic problem.

A government considering the Keynesian theory as ultimate certainty, applicable to any country in any century, would be considering it a set of eternal static truths essentially unaffected by future events so long as employment, interest, money, taxes, etc. remained a part of the nation's life. The kind of government on the other hand which is primarily concerned with present innovative operations might employ a whole lot of young "Keyneses" who would generate creatively and artisticly the action most appropriate to the particular challenges of the moment. This is what John Maynard Keynes himself did. He generated a new system of action which was relevant to the challenge of his own times. It was a part of those times. It was created by the times and it affected the times. It applied past experience and research to the crucial problems of the present. If we now adhere to Keynes' formula and not to the type of creative thinking Keynes himself used to develop this theory, then we will lose our understanding of economics and indeed of current life.

The Evolution of Two Ways of Thinking

I tried to put together the ideas of Whyte and ethologists and anthropologists such as E. T. Hall[9], Konrad Lorenz[10], L. S. B. Leakey and Leakey's interpreter, Robert Ardrey[11], and his further audio-visual interpretation by Lawrence Kubrick and Arthur C. Clarke[12] in the movie, "2001--A Space Odessy". It appeared to me then that people always try to set up some system of static ideas in order to organize extensive future plans. Leakey's data indicated that the development of weapons for hunting and aggression set human beings on the road to creatively competitive and progressive thinking. The use of weapons developed the human being as a separate species. After weapons came group planning for the hunt and the battle. Then came tools, language and writing. According to Whyte silent conceptual thought followed writing.

This early writing was ideographic. The symbols were pictures of actions and things. They did not represent sounds which in turn represented things. This direct graphic organization of ideas in relatively permanent form became an addition to the mind of man. Abstract ideas could be organized in writing materials without necessarily relying on the sequenced flow of symbolic sounds. McLuhan[13] demonstrates that the later development of alphabetic writing led the visual sort of sequencing to overpower auditory and tactile senses. The sequencing necessary for the alphabet prevented the further development of the total iconic grasp of a landscape or a concept. The alphabetically oriented man had more tendency to tease apart and to

analyze the elements of a landscape and to present it to himself or to others as a sequence of elements. Nevertheless, alphabetic writing made it easier for anyone to learn to write if only he could speak the language and could learn the alphabet. By inserting vocal sounds in between the concept and its written organization; however, alphabet writing only encoded sound onto paper. The reader first perceived a codified sound on the page. The sound then called forth the concept or the image. Today Chinese and to some extent, Korean and Japanese remain the only purely written languages in use. All other writing is simply graphically encoded sounds of spoken language. One effect of Chinese ideographic writing is that any literate Chinese person can communicate in writing with any other regardless of the particular Chinese spoken language each is able to understand. A more profound effect--not well studied--is the nonlinear iconic manner in which a literate Chinese or Japanese person can organize ideas.

The Far Easterner quickly grasps the total idea and then savors it and comes to understand its parts and implications. The short Japanese poems called Hai Ku are typical of this. An example is:

> Morning glory
> Twined around the well bucket
> Borrow water.

It may seem at first that the type of writing or even the type of language has little to do with the individual's ability to marshall ideas and to plan for the future. Benjamin Lee Whorf[14] among other linguists, however, demonstrated in the 1930's that the type of grammar one used made it easy to manage certain patterns of thought and hard or even impossible to manage others; for instance, as a fire insurance inspector Whorf found that fires were being started by careless storage of empty gasoline drums. When workers poured the gasoline out of a drum they chalked it "empty" and they believed their own writing. Actually the drum was full of an explosive mixture of gasoline vapor and air.

I have noticed in the case of mathematics that western school children and businessmen when they do sums in their heads or even multiplication, follow a few memorized paradigms. Their thinking follows the tables of multiplication etc... and not any mechanical device except that when pressed for accuracy they can be seen counting on their fingers--as if each finger were a separate number. The Chinese on the other hand, are persistant users of the abacus. When pressed for accuracy without an abacus, they move their fingers up and down as if they were pushing back and forth the beads of the abacus. In effect, they have incorporated the structure of the abacus into their mathematical thought.

I have noticed children and adults on the subways of United States reading the advertisements on the wall and moving their lips to try to grasp some unfamiliar words. I have noticed Chinese, Japanese and Koreans reading their own advertisements but they seldom moved their lips; they made little strokes with their fingers as if they were writing some of the more difficult ideographs. Westerners grasp their writing not only with the eye but with ear and tongue. Far Eastern people, on the other hand, grasp their writing tactilely with their fingers. They use the kinesthetic muscle sense in their fingers to help remember information gained from the surfaces of external objects as well as to ink up such surfaces in order to transmit information. They use the muscle sense of lips and tongue in speech, however, just as we do to project

information into the current social environment.

The reservoir of western information is stored in auditory concepts and visual alphabetic concepts. It is also stored in a few visual pictorial concepts gained from movies, comics, etc. The pictorial concepts, judging from the western painting and sculpture are concerned more with the play of light than with the tactile texture and form. The reservoir of Chinese ideas from which one projects information to others contains not only the sounds of the mother tongue but also a vast store of visual concepts which are perceived less as a play of light than as a guide to tactile organization and projection of ideas. Chinese painting attends to the calligraphic effect of the brush stroke more than to the naturalistic visual representation of a model. Thus it would appear that Chinese thinking in general involves the thinker more bodily and tactilely with his environment whereas Western thinking now tends to keep the subjective thinker aloof from his perceived or manipulated objects. Sound and light coming across a distance intervene themselves between subject and object and keep the subject and object farther apart than touch and muscle sense could keep them.

In summary then, the human species developed weapons, then tools, then spoken language, then ideolographic writing, then silent conceptual thought, then alphabetic writing. Alphabetic writing was one factor in divorcing the thinking subject (the self) from the thought-about object. Later, printing became a greater factor. It gave almost every European adult access to a whole library of social memory which became an auxiliary to his own mind for use in planning. Still later Europeans developed audio-visual techniques which tended to push masses of people back to a more auditory and also a more tactile inter-weaving of self with environment. The audio-visual techniques--photography, tape recording, television, movies, radio, computer, etc.--produced ephemeral or transitory feelings and ideas for the planner as against the ideas recorded permanently, reliably and accountably in the libraries and the bibliographies of the scholar.

The different ways of communicating and therefore the different ways of thinking which dominated men's minds in different centuries resulted in different degrees of separation of self from nature.

Consider the person who organizes his thought in a literary fashion. He can read and write, he speaks and writes a correct sort of English, he may even distance himself further from his utterances by spelling them out, typing them out or even printing them. It becomes easy for such a person to insulate himself from the people or the things he is talking, thinking, or reading about. He is not merged with the writing, with the landscape or with other people. He is aloof, objective, scientific, analytical, cool, manipulative and sequentially organized.

Consider the opposite sort of person who is illiterate or else who writes in a very personal signature-like handwriting and frequently draws pictures or who gestures and postures with every utterance. Such a person puts himself into his utterance, into his audience, into his landscape. He merges all his goodness and badness into his environment and he takes his environment's goodness and badness into himself.

Occasionally there are persons like Benjamin Franklin or J. W. Goethe or

Mme. de Staël who combined both types of thinking and feeling.

The Platonic World of Idea

Plato and similar philosophers developed a reservoir of ideas conceived as permanent, perfect and true--a secure refuge against the disorganized, unpredictable, uncertainties of the flow of political and social events. The linear alphabetic codification of spoken ideas into permanent paper-like materials stimulated such Greek philosphers to set up written plans or systems. They wrote up systems of mathematics and constitutions of government which Plato and his colleagues thought out so logically and consistently that people considered them true and unchanging. The Greeks and Romans often tried to impress these plans upon the world of social life.

In the middle ages, however, literary talents were reserved to an elite group of scholars, monks and nobles. The illiterate masses reverted to reliance upon an auditory face-to-face and tactile approach to social life. Medieval armies for instance were commanded by charismatic presence of a great captain (Shakespeares' Henry V of England said on the eve of battle, "We would not die in that man's company who fears his fellowship to die with us"). The Romans, 1500 years earlier, being more literary, were able to control their military operations by means of written orders which proceded over great time and distance. In the illiterate middle ages however these scholars were unable to apply their reservoir of seemingly eternal written truths to the flow of social and military events. The subjective thinkers could not remain aloof from the objects of their thoughts. They were involved in the very actions they were trying to control. The medieval army, for instance, controlled its leaders as much as the leaders controlled the army. The leaders could not remain distant and aloof from the troops, nor from the machines of war. Neither politicians or kings could remain aloof from the battle fields and the corn fields. People dispaired of applying the ideas of scriptures and philosophy to the real world. They only hoped to reach the ideal world when death had relieved them of this everyday world.

With the Renaissance, however, printing and the widespread ability to read and write emphasized vision once again as the primary sense for learning and planning. This intellectual distancing of the perceiver from the object he perceived promoted the developemnt once more of a dualistic type of person. This Renaissance person identified himself as a thinker in a world of eternal truths and a priori judgement quite separate from the world of actions and events. The subject mind which did this kind of planning seemed distinct from the object body which executed such plans or upon which such plans were executed. Men as thinking subjects could stand aside and observe their own bodies as if separate from themselves. Men could even observe their own thinking as if that thinking were separate from the mind which was doing the thinking. Significantly, many Renaissance techniques projected and received information and action over a distance--navigation techniques, mail service, the microscope, the telescope, the cannon, the heliograph, and other signaling devices. Even courtship became more intelluctual and literary. People became newly concerned with the verbal projection of love-messages and the exhibition of self as lover. From Petrarch (c. 1330) onward, people produced myriads of formal yet intimate love lyrics, love songs and love letters. Tactile expressions seemed relatively less important.

The decrease in personal tactile contact seems to have had one especially powerful effect on Europe: it eliminated leprosy. Michel Foucault[15], in

his book, Madness and Civilization, discussed how the thousands and thousands of lepers who were stored in the lazarets or leprosariums eventually died off during the 14th Century. An approximately equal number of schizophrenics replaced them in the same hospitals but virtually no more lepers appeared. It must be remembered that leprosy could only be transmitted by intimate and frequent tactile contact between persons. Thus, leprosy is very common in Africa and Southeast Asia where people habitually touch each other far more than in modern Europe or North America..

Typically leprosy first manifests itself as a region of anesthesia on some part of the body. It commonly appears for instance on the forehead or the buttocks of achild. These are points of frequent contact between the child and members of his family. When the child is carried on the mother's back his forehead can rub the leprous nodules on her back for many months. It is very difficult however for leprosy to move from one person to another in countries where family and friends avoid touching the child as they do in the United States by carrying babies around in now popular plastic frames.

In contrast many Africans today attend well to a conversation only if they are touching the other person. Men often walk down the street holding hands or embracing each other. In Southeast Asia I have seen doctors go into their waiting rooms and put their arm around a strange patient to bring him into the office--a rare gesture in the United States. Most of the people outside Europe and North America seem to be in a state of close tactile communication similar to the closeness which prevailed in Europe when leprosy was rampant.

It would appear then that the habit developed in the early Renaissance of handling things and people at a distance decreased the incidence of leprosy. The mechanical means of distancing self from objects (means such as telegraph or rifle), probably grew out of the cultural need for the individual to affect things at a distance instead of being involved in them in such a way that self and environment were affected together. So Renaissance man separated self from others, mind from body, dream from reality, painting from the room and instinct from intellect. This dualistic view of the world brought on the development of the dualizing mechanical techniques such as printing, telescopes, cannons, etc. On the other hand, the mechanical dualizing in turn increased the conceptual division between self and world or self and other people. Our doctors for instance will distance themselves from patients by avoiding home visits and also by prescribing pills as a primary method by which they can care for the patient. A psychiatric patient for instance may be told in effect to form his main relationship with a bottle of pills rather than with the doctor.

Practically all people use some sort of categorizing of concepts and symbols to allow persons to think and to plan. With some people, however, and at some times in history, persons place much more emphasis on categorization by tactile and oral conceptualization than by visual conceptualization. Ideographic writing, phonetic writing, printing, televison, etc. have profound effects upon the type of categorization, the type of thinking and the habits of human contact which prevail at any one age of life or any one year of history.

Piaget[16] and others working with European children, have shown that the words or the concepts of action and sensation into which people categorize their world of thought, are not a "copy" of a set of ready made objects on earth. Conceptual relations, such as cause, time-sequence, or musical scaling, do not

have a one-to-one correspondence with ready made relationships among materials and energies in the world of facts. A person gains knowledge of objects and of their relationships by carrying out activities which bring about changes in these objects or relationships. Thus, by arranging stones in different patterns, a child can gain certain concepts about the sequencing of sizes, weights, colors, relationships, lines, clusters, sets, etc. These operations construct within the child a feeling for, and a concept of, certain relationships such as time-sequence, cause and effect, transformation of size, pattern changes, etc.

It would appear that all people construct some system or set of static ideas in order to think abstractly and to plan at all. At least they have words. These words become tyrants. Persons marshall their thoughts in accord with the categories of actions, thoughts and feelings available in their language. A time-worn example is the Eskimo who sees different qualities in different snow drifts because he has many different words (categories) with which to perceive snow. Those who live with Eskimos begin to learn these categories and to perceive better the kind of snow which is: (1) wet and sticky and makes good snowmen, (2) dry and granular and makes high drifts, (3) finely powdered like ricestarch, flows like liquid air, screams like a cat fight when you walk on it and (4) hard, stone-like quarries of snow which sound hollow like pumice stone and can be sawed to make building blocks. The natives of Vermont and Montana have these same snows but they do not have these same categories in their mind so they cannot plan and think and talk about them quite so readily as the Eskimo.

Plato and the "Dualists"

At some times in history and with some groups of people, thought begins to move mostly in a world of ideas which is seldom checked out against the world of facts and things. Thought in abstraction then constitutes the world in which that group of people must live. This occurs most often in Academia.

About four centuries before Christ when alphabetic writing was becoming prevalent, Plato[17] set up very clearly a world of ideas and concepts. He called it "the real world". This world contained the concepts, for instance, of an ideal house or an ideal chair as a sort of blueprint or essential plan. All actual houses and chairs would be imperfect representatives of such plans. None-the-less, the plans could be used to create other plans. Plato and his friends tried to set up a collection of eternal truths which would be unaffected by the transient events, accidents and imperfections of the world of things.

This world of truths existed neither in time nor space. It was considered absolute and eternal. The world of objects however, which was extended out in space and time, was always transitory, always changing, always uncertain. Falling bodies, for instance, in that world of objects, never fell with velocities which fit exactly the law of gravity. Much less did human behavior fit legislation, nor did a state's administration fit its written constitution. It appeared, indeed, that people did not behave perfectly themselves. They only expected others to do that--expecially their ministers, teachers, physicians and policemen.

Thus, Plato could devise a theory of education which would present great truths in a very logical fashion. But, the teacher who faced a particular group of Greek children might not be able to carry out those theories at all.

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Even so, Plato's theories were less distant from the world of human interaction then were the theories of many later, more solitary arm-chair thinkers who figured out their theories by arranging ideas entirely within their own mind. For Plato, in a typical Greek fashion, developed his ideas by interaction among various men who had various points of view and various concepts. In Plato's dialogues it is clear that at times the speakers touch each other. Significantly, Plato himself was a wrestler. Plato's theories were thus developed in conversation and even in action rather than in the isolated contemplation more typical of Western Europe.

In his conversations, Plato was fond of beginning with a set of ideas and reasoning onward through other ideas and finally ending in further ideas. Of course, many men before him had reasoned by means of symbols and concepts, but Plato publicly demonstrated his own attachments to a very extensive world of ideas. The spread of writing had greatly strengthened the ability to use extensive ideas; for the world of ideas dealt with adding, subtracting, logicizing, hypothesizing and memorizing. Writing extended the realm of memory. As persons depended more on writing, they lost some of their individual memory skill but they gained access to a very extensive social memory in the libraries and schools.

From the 14th century into the 20th century, the Renaissance brought back a dualism similar to Plato's. It dealt with a split-world--first the world of subjects or observers, and second, the world of objects or things which the subject observed and worked with. The observer or doer was considered distinct from what he observed or did. He had free-will to make decisions uncoerced by the environment. He had individual autonomy over his own person and his own thinking. He could even become at times an observer of his own acts of observation. He paid attention to himself. He became more conscious of what he was doing and thinking.

Information and Organization

Adaptational changes occur when the organism (the individual), the species, or the culture) has gained information. Information is always gained by the formation of some structure--a long-lasting structure if the information is retained long. Such a structure, for instance, is the gene or the double helix which records changes in heredity. Another example is the educational programming of the brain or the production of libraries or tape recordings which may become an integral part of a society's thinking apparatus, or of an individual's. Lorenz[10b] thinks that such a structural change always means that some pre-existing and formerly useful structure has to be sacrificed. Flexibility permits change but the change brings a "stiffening" of flexibility into a static, but temporarily useful structure. For example, Lorenz says a worm has great freedom of motion. A man with his stiff bones and restricted joints, however, has limited motion, but he can stand erect. Similarly, in order to gain new knowledge or skill, we must always break down some previous pattern of knowledge or skill which had once appeared to be a final solution. That static solution is the state of <u>being</u> well-adapted to the world in which we live. The act of <u>becoming</u> adapted however consists of a process of changing by eliminating some of the old solutions. An organism could not survive unless it maintained a useful interaction between two important forces: (1) the conservative forces which hold to the static solution and (2) the adventurous forces which bend the organism

toward a new solution. Structure can accordingly be fixed and unchanging or it can alter and become a new kind of structure.

Twenty-million monkeys pecking on typewriters for twenty-million years produce no literary information. They only produce a chaos of alphabetic characters. Almost any conceivable combination of letters can be found in that chaos. A pattern or form impressing itself from outside that typing system however can organize part of the chaos.

For instance, an English professor could scan through all that chaotic lettering and find Milton's sonnet "On His Blindness". The professor, having the form of the sonnet within his memory, discovers that sonnet somewhere in the chaos. He delineates it out of the chaos and in effect he organizes the chaos so that the chaos is then known to have that sonnet within it. The chaos has assumed more meaning within itself. It has been in-formed. It contains information. Thus, the chaos seems to communicate to the professor. The professor attends to that communication and sets the form of the sonnet into the organization of his own thought. He has in-formed himself.

The professor does not merely match the sonnet from the chaos with the sonnet he carries in his memory. He attends to other partial forms within the chaos, forms which are only approximate sonnets, or perhaps single words, but which stimulate his ability to modify and organize thoughts in his way. He takes the hints and suggestions he gets from inexact "information" and gives them more meaningful organization. He makes them more informative. This is to say, the creative organizing function of the mind, interacting with the chaos, increases the amount of information in the universe. The mind decreases entropy. By small work, the mind produces large information which makes it possible to do much more work.

If we assume a unitary stance and free ourselves from the subject-object dichotomy we can say the chaos of letters attends to the professor and informs itself with the sonnet. The professor attends to the chaos and informs his own memory with the sonnet. As interaction between chaos and professor proceeds it may mold and polish out other sonnets never before created by any author--but only randomly and meaninglessly tapped out by monkeys.

The unitary person would then say there is more mind in the world. Anaxagoras in the generation before Plato felt that the ultimate element underlying all of the universe, all Creation, was Mind--a sort of universal mind. Plotinos, belonging to the newly arising Byzantine-Arabian, unified personality saw intellect as an analogous substanding element of creation. Spinoza, about 1600, retaining some Sephardic unitary attitudes, saw universal intellect in a similar fashion. These three philosophers were essentially ignored by modern dualistic thinkers.

The Consequences of Europe's Attention to Plato

Whyte (as far as I know) does not expect the world of Plato's ideas to vanish from human thoughts in the future. He does however expect Plato's world to merge interactingly with the world of space, time and events--not to remain academically detached. Deliberate, conscious "self-aware" thought will merge with intuitive, artistic self-involvement in the world

of action and emotion. This merging of the deliberate Platonic thought with artistic work will organize most useful behavior.

This merging probably sounds immoral to the Calvinist since it does not insure an unchanging character for an individual in accord with eternal moral values. Furthermore, the merging sounds impossible to the type of thinker who utilizes stereotypes and dichotomies in order to do any personal planning at all. This thinker has been rewarded by sufficient, practical results to convince him that he exists as a self apart from a contaminated world. Indeed, this conviction seems to be such a reward in itself that the thinker requires but little evidence to develop a faith in it.

Such a thinker often gains self-development by paranoia. When he is a child his parents tell him what is good and bad, and say that they expect good behavior of him. In fact, the parents often tell the child he is good already. They mean, they could not stand for the child to be what he already thinks he really is inside--a rather bad boy. Consequently, the child shuts his eyes to all his own hateful, stupid or lazy feelings and looks for those feelings out in the clutter of the world around. He finds such badness in others and says "it is they who are bad--not me"! This child is like a professor who finds an obscene sight in the mass of typing done by the monkeys. He informs that mass with his own perconception, then he says that the monkeys are pornographers.

Such dualistic human beings develop guilt. The unitary man however does not have guilt. He only has shame. When he speaks of guilt he is referring either to a humiliation he feels in front of others or else to a debt he owes; for example, to his parents. This debt he carries with him always. He is always conscious of it and may feel it as a weight, but it does not have the sense of sin.

Unitary man carries humiliation with him because he knows other people have memories. It is not his own subjective memory which counts here. Humiliation or shame requires that both self and others exercise memory. A person all alone cannot have shame. The feeling of "saving face" before others is a continuously lived process. It is not a fixed image like the ideas or blueprints in Plato's world of ideas, nor in the dualistic man's image of self as an unchanging spirit. Nevertheless, the unitary man's "face" is about as near as he gets to the self felt by the dualistic man. This "face" is near to that common ground between existentialist and behaviorist thought which says, "I am my behavior".

Losing face, the unitary man experiences a gap in his organism-environment systems. In part he ceases to exist. The dualistic man has an advantage here. Humiliation does not so utterly devastate him. Accordingly, he does not have to live so completely in the flux of present social events. He considers that his real self has to reckon, not with present society, but with an incorporated society peculiar to him as an individual. This inner set of ideals is his god. Ultimately he has only this one god to reckon with--not the many whims of the gods nor the many conflicting demands of his neighbors. The humiliated or shamed dualist can seek refuge in his inner-self; it is hard to shame away his existence. He may escape shame by keeping out of society's view but guilt would still destroy him. The inner-self, the sensitive, moral conscience sees all. It remains a dissociated subject watching the person as object.

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Guided by his conscience, guided by rules which he considers to exist in an eternal world of spirit outside of space and time, the dualist person is full of "shoulds" and oughts". Split between his dichotomies, he lives out a relatively solitary and schizoid life regulated by guilt and moralism--deluding himself that he is autonomous and is making all his own decisions.

Nevertheless, European man, functioning mostly as a dualist from the 14th to the 20th century, maintained his tremendous advantages. He could make objective discriminations which gave him great control over nature and over other men. Nature consisted of objects ("not me"); other men consisted of objects ("not me"). The belief in a better world than that of his everyday life gave him a refuge, allowed him to tolerate--even without much support from others--great oppression, great humiliation, great failure.

His dualism also allowed him to develop an extremely romantic type of courtship ritual and a dramatically introspective art and literature such as his personalized lyric poetry. He developed faith after faith and believed in every new faith as self-contained, absolute and eternal. He believed not only in a succession of religions, but in a succession eventually of religious wars and of successive theories of politics and science. The theories of Ptolomy and Aristotle--so certain, so absolute and so easily proved in everyday experience--gave way to the theories of Galileo and Newton, and these, in turn, gave way to the theories of Einstein and Planck--each more distant from common sense and each harder to prove than the preceeding theory. Uniquely great loves, marriages, theories, battles and heroes succeeded each other in the dualist's devotion--each segregated out as the greatest, the most sacred.

The dualist European man has usually thought only in dualist ways and so he believes that his kind of thought is universal and quite natural to all man. He thinks he is just as aware as is the Asian or the pre-Socratic Greek of the extent to which his mind is merged with others or his individual figure is merged with its cultural background. He thinks that all men distinguish figure from ground in just the way he does. As an example, we perceive that Renaissance artists and many modern western artists are quite cognizant of figure against ground. They usually consider very carefully the background upon which they paint their figure. Books on composition are careful to get the student to realize that whenever he lays out some forms such as a rough silhouette in the middle of his canvas; the surrounding canvas will automatically produce the negative of that form. This is really an example of dualistic thinking. The artist is not integrating his picture with the world, he is integrating it with its own self--for that self is considered to be the figure within its frame, the picture upon its canvas.

The European canvases since the early Renaissance have typically been framed and thus given definite boundaries which shut it off from the rest of the world. Within such a boundary of course <u>is</u> the negative of the silhouette. Similarly, the Platonic world of ideas is shut away from the world of events. Similarly, also the great conclusive system of Greek geometry organized by Euclid was always thought to be internally consistant, to depend on no other system of ideas outside of itself--until the 1930's when Goedel[18] dropped the subject-object dichotomy and proved mathematically that there could never been any system of thought which was sufficient unto itself. All systems of mathematics, politics, philosophy and science merged into all other systems.

Far Eastern painting is almost never framed. It merges itself with the world

upon which it is painted. Its beginning seems to be somewhere in the middle of that world. Many Far Eastern paintings are done on scrolls which have no concern for the proportion of length to width. The viewer simply unrolls an arbitrary length of scroll and lets his eyes wander along it. Any segment of picture is itself unified with the whole. It does not seek to be an isolated perfect system unto itself--autonomous, self-consistant, aloof, objectified. Rather it is a part of the viewer. Indeed, the viewer is rather easily led to paint parts of the picture with his own eyes, his own imagination as he explores his way through it. In the distant mist he sees more mountains. In the few strokes that portray a countenance, he sees a quiet emotion.

Furthermore, the Far Eastern picture has no line perspective, no point of view which forces the viewer into the illusion that he, himself, is standing only at a certain point in space. Consider, however, the European picture painted between the Medieval and the later modern times. Velasquez's "Surrender at Breda" (about 1650) leads the spectator to feel that his eyes are level with the horizon and ten feet in front of the victorious commander. The musketeer on the far left is looking squarely at the spectator. If now the spectator moves far across to the side of the room, he will still feel that he is ten feet from the victor and that the musketeer is looking squarely at him.

Dualistic persons living today keep themselves ever alert concerning new self-contained systems to put their faith in--whether they be drugs as the answer to all problems or politics or new-sex or weapons or disarmament or religion or high intellectuality. He is always asking "what's up". For the choices are very limited in the dualistic world of individual "freedom" just as the choice of candidates to vote for is limited. The dualistic person pretends that he fits this world of facts and events to an intellectual world of truths and certainties.

Unitary man, on the other hand, does not think that he completely abandons any faith or any human relationship in order to move his still-the-same self into a new relationship. He does not divorce himself from one friendship or kinship in order to dedicate himself to another. For instance, he does not abandon his closeness with parents in order to develop new closeness with spouse and children. He retains rather the ability to participate in the ways of thinking and the feelings of all the ages of his individual life and of all the important human relations he has ever experienced. His different ways of thinking are thus synthesized--not teased apart analytically. The child-like feelings he developed as a six year old he holds readily available for dealing with the present world. He re-uses once-understood systems of mathematics, music or craftsmanship. Nevertheless, he does largely outgrow one relationship and moves his main life and experience into another. He does not romantically idealize and preserve a fixed interest in his former life as a six year old, nor in his first love affair. Rather, he integrates all ages and all grammars of thinking and behavior into the present natural world which he is a part of.

The Major Steps in Man's History

After weapons, language and writing had separated the human species from other animals and made history possible, Whyte believes that between 3,000 B.C and 4000 B.C. three great processes brought profound changes to historical man:

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(1) The establishment of great empires which organized most of the known world under one central administration.

(2) The establishment and spread of monotheism which conceived the world as fathered by one universal god.

(3) The emergence and widespread use of universal ideas like those of Plato or of Newton, thus allowing the development of rationalistic and objective modes of thought. To these three I would add one more:

(4) The "megabrain"--the intellectual symbiosis of creative groups of scientists, businessmen, etc. who pool their thought to produce ideas more far-reaching than any single man ever could. Examples are: "The Copenhagen Group" of the theoretical physicists which developed the great revolution of modern physics in the first thirty years of this century[18]. Another "megabrain" would be the "Manhattan Project" which developed the atomic bomb and nuclear power. Other examples are the various "think tanks", such as the Rand Corporation and the Hudson Institute.

Today we tend to think of "primitive man" as someone we do not know very well who lives in a non-industrial country and is impulse-ridden or childlike. We think he does not restrain himself enough to allow for cogitation or introspection between his perception of an immediate need and his action upon it. Of course, we think that even the most primitive man was more restrained and reflective intellectually than the highest animal.

If we follow L. S. B. Leakey[11], we should assume that this intellectual difference between man and animal developed when certain animals began to use weapons even against their own species. Planned and coordinated hunts, and especially battles, necessitated language. Eventually, tools introduced other planning delays between impulse and act. Thus, the human species came into existence.

Nevertheless, it seems to me that the universal empires, universal gods, universal ideas and the megabrains became highly developed mostly because of the universal writing. Written orders, accounts and other information allowed the spread and the continued management of such empires as those of Sargon I, Thothmes III and Shi Huang Ti. Writing promoted the operation of commercial and military enterprises extended over much space and time. With the Hebrew scriptures, a single and everlasting law and way of thinking could be organized as The Word. At the advent of Christianity, St. John could then write "In the beginning was the Word and the Word was God". The scriptures provided a fixed memory for the society even though but few people could read them.

When literacy became widespread in Periclean, Greece or in Renaissance Europe, many schools, businesses, governments and research groups could use universal ideas to help manipulate nature and human beings.

Nevertheless, Whyte believes that these three universalisms--empire, God and rational ideas--were achieved at the price of some disassociation of man's personality. Individuals who formerly oversaw all the social and economic functions of their small worlds had to change in the time of big empires so that they could think in terms of their speciality within the empire on the one hand and in terms of their role within the local families and neighborhoods on the other.

Similarly, polytheism required the individual to rely on himself as an appeaser or manipulator of many spiritual forces. The universal God however

with His promise of a paradise to come and a concentration on a single set of ideal laws, split a person's thought between "Sundays and weekdays" or between the world of a person's own reasonable plan and the world of uncontrollable events.

Universal ideas spread this disassociation into practical, secular life as men tried to use ideal laws of physics or principles of philosophy to improve conditions of daily life. Universal ideas provided a world of thought which an individual could master and from it view the contrasting world of daily events. This view allowed the individual to look at his own life as a part of those daily events. He could become more reflective and could see himself both as a subject doing something and as an object being thought about. He thus split himself into a dualism. He also conceived of himself as intellectually detached from everything around him including all other people. This detachment process however was not the beginning of individualism itself. It was simply the beginning of intellectual individualism.

The Rise of Individuality

According to McNeill[20], the Ionian Greeks took the biggest single step in the development of the individual as a self-reliant person--a person necessarily respected by others. This step occured in the Ionian hills and peninsulas where the refugees from the Dorian invasion about 1000 B.C. had to devise a method for poor foot soldiers to face the terrible charge of Asian calvalry. These Greeks invented the phalanx, a line of armored spearman about eight ranks deep. Such a phalanx could impale a charging horse on its spears provided no break in the line allowed the horsemen to get behind or among the foot soldiers. The phalanx required a discipline and coordination of techniques beyond what men in battlefield groups had ever before attempted. Greek citizens now drilled every day. They essentially danced into battle with great precision and complexity of coordination--with great dependence, trust and respect of each individual upon each other individual. Because of its group coordination, the Greek Phalanx developed in its members an individuality of skill and practice just as a chorus produces in its members a skill in singing together.

Six hundred years later, Plato[17] produced an individuality of intellect in his writing and helped at the same time to impose dualism upon individuality. In his Epistles, St. Paul combined montheism with rational intellectualism and produced a subjective sense of personal sin--sin as an internal, unique and individual experience making possible still more dualism.

The unitary people of ancient times, of the Middle Ages and of some of our present developing countries, participated in both compassion and sadism if circumstance made both of them inevitable in daily feelings. The unitary individual was usually quite conscious that he exercised an equal amount of sadism and compassion--perhaps sometimes even toward the same person. Some of these people doubted, indeed, if anyone could experience any feeling without, at the same time, either experiencing or storing up for later use an approximate opposite to that feeling. Some personified in the god Krishna the quality of tranquility and at the same time the quality of anxiety. Another god personified strength, and at the same time servility.

The Christian intellectual person however was dualistic enough for example to imagine that he was ninty-percent compassionate. He pretty much denied his sadism. He usually considered that the behavior of Jesus, which resulted in crucifixion, was an example of the deepest compassion toward mankind.

The Coming Unitary Life

This Christian shut his mind however to the notion that this same behavior stimulated a whole Roman-Jewish community to become extremely sadistic. I believe that Whyte would say however that the non-intellectual Christian serf of the Middle Ages--living close to nature and far from literacy--would be much more likely to unify within himself his own compassion and sadism. He might not like the combination but he would accept it and would not deny one whole side of his total feeling.

When unitary man set out to change the culture of another society to make it compatible with his own commercial and spiritual interests, he usually said something like this: "Power comes out of the barrel of a gun" (Mao Tse Tung) or "woe to the vanquished" (the Gaul who threw his sword onto the scale when the Romans complained of his dishonest weights). This cruel sort of assertion was all right providing the unitary man could still merge himself into a group consensus where such assertions were acceptable. If unitary man behaved so cruely that his parents or his tribe would disdain him, he kept that behavior to himself lest he be shamed. As long as only he himself knew about it, he did not feel any pain. If his tribal group did shame him, he had one other escape route; he could become contrite, do penance and then become accepted as a "new person" into his tribal group.

The dualistic Christian however would feel guilt if he kept his cruelty a secret. For the Protestant in his extremely well defined dualism, even confession and forgiveness was not easily available. In order to avoid guilt he had to: (1) avoid the cruel act or even the thought of it or else (2) perform the act but then deny to himself that he did it intentionally or (3) perform the act but convince himself and all his acquaintances that it was really a righteous act done for the good of the very people he had damaged.

Following this last principle, Western dualistic man has sent missionaries, commercial enterprises, educators and conquering armies out to alter the culture or the tastes of other people. He derived considerable commerical or spiritual satisfaction and profit; yet, he imagined that he had not disturbed the foreign culture in any way that foreigners would dislike if they only knew better. In this way, the dualistic man kept his thoughts about himself (as subject) quite separate from his thoughts about other people (as objects). He did not consider himself a part of those people. He could not feel as they felt. He could only categorize evidence; and as any judge knows, only evidence which can be written down is reviewable and can take on the weight of law. The most heartless acts of dualistic man were within the law.

The dualistic individual may adopt such devotion and faith in a cause that he does not sense any guilt which would ordinarily arise from the fight for that cause. This development of faith in place of guilt is what Whyte calls "religious conversion". Thus, the secret police in the Gulag Archipelago[21] were aware of no guilt for the cruel punishments they inflicted upon political prisoners. They were so devoted to their own cause, their own profession, their own expertise that they believed they were bettering the world. Similarly, Josiah Wedgewood was aware of no guilt for his exploitation of little children in his china factories. Tobacco manufacturers apparently felt perfectly humane in their advertising which encouraged young folk to take up smoking without regard for health, but to consider only the social conformity and the pleasure involved. There seems indeed to be no expanding corporation which feels any compassion for the people it encourages to spend more money

than they can afford. Cortez felt he was a hero when, with a single battalion he eliminated a civilization more highly organized than his own.

Until recently the work of foreign missionaries, diplomats, foreign aid and expeditionary armies from the West felt there was nothing wrong with translating foreign peoples over into ways of thinking, working and spending which were in the best interests of the West rather than any interest of imroping the foreign culture. We have lately concerned ourselves a little more with the problems of living among other cultures as we have listened to anthropologists, to soldiers returning from Vietnam and to Peace Corps volunteers who have returned from developing countries. Such global thinkers as Marshall McLuhan[13], Buckminster Fuller[22] and Konrad Lorenz[10] have turned Western people's attention to the welfare of all cultures as separate organisms and to Planet Earth as a spaceship on which everyone collaborates or else everyone becomes rapidly extinct. Today, then, as the West becomes more unitary it also tolerates and respects more of its own sub-cultures such as the American black man, the Chicano and the American Indian. Even the Gypsy in Europe and the Montegnard in Asia begin to attain human rights comparable with the majority culture in those regions.

This is not to imply however that the future will bring a perfect cross-cultural tolerence. Americans would hardly tolerate a culture whose religion demanded that it burn all Americans at the stake.

The Jewish Contribution to Unitary and Dualistic Man

Whyte considers that the Jewish people even in modern Europe remained more tribalistic than Protestant peoples and more unitary in their thoughts. The Jews were not so concerned with the future eternal life for the individual as they were with maintaining good works and a good reputation for the tribal line on earth. They hoped that God would eventually descend to live with them as His chosen people rather than winnow them out and take them up to an unearthly kingdom of God. Thus, the Jews were less concerned to split the universe into two incompatable parts--heaven and earth.

Whyte, nevertheless, believed that in the very midst of their unitary feelings the Jews developed a dualistic aspect to their thinking, they separated the world of facts from the world of ideas even earlier than Plato did. Thus, they developed a literature and a ritual which promoted reverence toward the world of the intellect. When the Jews lost their national territory they tried even harder to be supreme in the territory of the spirit or the intellect.

The Middle Class Contribution

Whether or not these notions about intellect really applied to the Jewish people, they did apply to the European middle class as it developed in the Renaissance. The middle class could say that since it had no worldly dominions in the form of fiefs--as the nobility had--it would at least be supreme in the world of commerce which required not blue blood but cleverness plus a great store of intellectual knowledge. The intellect which utilized the static laws and principles of accounting, engineering and psychology became the great treasure of the middle class--a treasure which the moth and rust could not corrupt.

A child with low intellectual capacity was therefore considered a misfortune

to the individual parents. Middle class parents then wanted to return such a child to the "tribal" responsibility of the state or church because this child did not have the capacity to emerge as a distinct and separate individual with responsibility for his own decisions. The "tribe" had to help this child make decisions just as the "tribe" had done for all the unitary people of earlier times. The middle class set relatively less value upon beauty, physical strength, athletics, military power or faithfulness and dependability at monotonous but necessary chores. These virtures were of little value in a world assumed to be mostly intellectual.

Dualistic man as we know him today then is not only a phenomenon of Renaissance Europe, but of the Reformation and of the industrial middle class.

If thinkers such as Kirkegaard and Freud had felt less personally distinct from "primitive" people and had been more cognizant of the lack of the European type of guilt feelings in the highly cultured Asian peoples, they wouldn't have been so ready to believe that guilt was inherent in all members of the human species, nor that certain taboos were universal. They would not have assumed that every individual had instinctual drives towards certain anti-social behavior as an essential quality of their humaness. These thinkers might have considered that most of these guilts and instincts were an essential quality only of their modern Europeanness.

Summary of Historical Steps

To recapitulate then, the use of weapons and tools led to spoken language, these three techniques produced human beings as distinct from animals. The use of writing then produced historical man. Writing facilitated the development of universal empires and the molding of groups of specialists into a vast organization whose memory could be stored in books and whose communication could be transmitted accurately over vast distances and times by means of written messages. This molding of specialized persons into a vast mechanical organization is what Mumford[23] called the "megamachine". One of Mumford's earlier megamachines was the bast bureaucratic organization of Egyptian workers and administrators which produced the pyramids.

The organizing of many people over wide space and long time stimulated the development of monotheism--as temporarily in Egypt under Akhenaton. Later on, and especially with Plato, society developed universal ideas--not necessarily related to monotheism. Alphabetic writing and portable writing materials disseminated ideas and controlling directives to a wider range of social classes than could the old ideographic writing which was so difficult to master.

A certain amount of dualism had developed with the first true human beings. Weapons and tools had enabled them to distance themselves from the objects and people they manipulated. Language made possible some controlling and some learning between people without their utilizing their total body and all senses. Spoken language emphasized the use of hearing rather than vision or touch. Spoken language transmitted thoughts and ideas in a linear sequence with the flow of spoken words over time. "Iconic" ideographic writing brought back an emphasis on vision which could grasp a complex situation or concept almost immediately--as one may grasp a landscape painting almost instantly compared with the linear sequencing of perception in order to grasp a song. This immediate grasping of a concept or emotion was more totally self-involving than the delayed sequencing of ideas

over time. Later, however, without alphabetic writing, people returned to a linear sequencing of emotions and other communications. The alphabetic language guided thought in linear sequences, not only during writing and reading, but even during silent, creative thought. When people picked their way carefully through a sequence of ideas, out of their memories and immediate feeling, they would likely be overwhelmed if a total iconic revelation burst open a mass of feelings and memories. They needed this vast store to remain outside of awareness. People could think then with a focused awareness rather than by a total intuitive impulse arising from all their unconscious emotions, habits and concepts.

Plato constructed dialogues in which one speaker would oppose a linear sequence of ideas against another person's sequence. The interaction of these sequences teased out into clear awareness certain notions about universal ideas of justice, love, methods of obtaining knowledge, etc. Most importantly in his dialogue Plato segregated or "dualized" the world into two parts--a world of ever changing trees, people and oceans, on the one hand and a world of fixed and eternal ideas about trees, people, justice, etc.

Thus, after Plato, persons were able to examine themselves as if there were a difference between the examiner and the examined. They split the world into the realm of the objective and the subjective, the body and the mind, the unconscious and the conscious, the realm of things existing in space and time, and the realm of static ideas existing apart from space or time. The Roman Empire was organized on a dualistic and linear line-and-staff structure. But, in the midst of this bureaucratic society, many people began to develop their potential for unitary thought. They grasped ideas iconically as immediate wholes. They thought more by intuition, less by logic, more by superstition, less by intellect--or at least it must have seemed so to the rationalistic bureaucrats of Rome. This sort of thinking pervaded much of the late Roman Empire--the times of St. Augustine of Justinian and of Boethius. As time went on, other unitary peoples developed outside the world of Roman or of Byzantine culture. These were the people who built the tomb of Theodoric at Ravenna, that megalithic pill-box with its massive dome cut from a single rock. Such people by word-of-mouth and personal example managed the armies, or rather hordes of Attila and the tribes of Charlemagne. They wrote Beowulf the Song of Roland and the Nibelungelied. They were still largely unitary when they fought the crusades and built the great monuments of Chartres, Summa Theologica and The Divine Comedy. We usually lump all this unitary thinking under the term "medieval".

The Renaissance however brought to European peoples after 1300 an emphasis on dualism accompanied by a growing avoidance of tactile communication. This relatively greater reliance upon eyes and ears allowed people to stand aloof from one another and to be objective, analytical and critical--that is, dualistic. This detached "objective" behavior essentially eliminated leprosy from Europe but it apparently brought about more segregation of schizophrenic and other deviant people into the great hospitals. It also produced a reliance upon a love of firearms, telescopes, microscopes, credit money, signaling devices and navigation devices; all of which increased the feeling of aloofness and objectivity.

In the 18th century as Renaissance man entered the industrial revolution, his organized "megamachines" of interlocking specialists could consider

every worker of a certain speciality equal in value to every other worker. By counting and controlling equal-valued dollars and hours he attained "accountability" and ever more detached control of machines and persons. The prime model here was the printing press[13] with its equal-valued, massproduced letters.

Painting was one symbol of this aloofness and objectivity. Typical Renaissance painting from the 14th to the 20th century was framed apart from the rest of the world. Line perspective kept the observer at a precise point of view from outside the picture. This dualistic Renaissance observer considered that the subject-observer was distinct from the object observed. He set man distinct from animals, mind distinct from body, conscious distinct from unconscious, reality distinct from dream, public White House image distinct from private Watergate image, and a world of ideas distinct from a world of unpredictable events.

Apparently the Renaissance will now employ the rest of the 20th century to fade slowly away. Some of the last great developments of the dualistic man of Renaissance Europe were bureaucratization, the multi-national corporation, the atom bomb, the megabrains, the flights to the moon and the laboratory manipulation of genes. Nevertheless, these great efforts to affect distant things in an objective and aloof manner are now opposed by the contemporary development of communes, kibbutzim, wars of infiltration and terrorism utilizing powerful individual weapons. These movements promote a versatile individuality. Further promotion comes from the resurgence of ethnic and sub-cultural power, the development of gurus, highjackers and generalist, humanistic consultants, the renewed interest in mysticism, ufo's, psychedelic drugs, astrology and a fear of research which pollutes the world with new knowledge and disturbs individual human life with social progress. In addition, we have a growing personal openness of politicians and other leaders on TV where by word-of-mouth and personal example, they become new Caesars or even Charlemagne's.

Examples of Dualistic vs Unitary Thoughts

Israel. The Zionist Jews of today exemplify the current mix of dualistic and unitary thinking. They have set up a European nation-state as if they were going to compete with other nation-states in the manner of the last century. This nationalism seems to be at loggerheads with such modern tribalistic developments as kibbutzim or the sense of international kinship on Spaceship Earth. This Jewish nationalism seems anachronistic in the face of those nation-states which are now beginning to merge into a Global Village under the universal audio-visual communication (TV) or in the face of the multi-national corporations which absolve themselves from allegiance to any nation. The state of Israel seems anachronistic too, in the less developed countires who have the power of over-populating and over-garbaging the spaceship into which mankind now crowds. The significantly more modern fact of Zionism is that this new state derives a crucial part of its national support, not from Israel as the people within a territory, but from Israel as a world-wide consensus of Jews and Jewish sympathizers. From its very beginning then Israel actually merged with the rest of the world in a manner which future people will probably follow as they come to realize that the garbage which they must now breathe, eat and learn comes not merely from some enemy, but from themselves. Friends and enemies are almost indistinguishable and randomly infiltrated. People are simply collections of shipmates.

The Coming Unitary Life

Scandals. News media thrive on scandals such as war atrocities or Manson mass murders. But the most exciting scandals are those about teachers, pastors, policemen or doctors. People need once in a while to see these "saints" as no better than anyone else. People like to think that maybe the hero or the saint has a mistress or is homosexual. Such thought makes miserable persons feel normal and self-acceptable concerning their own little guilts. The important thing here is hopefully to see within society the good people infiltrated among the bad and to see also within the individual the righteousness infiltrated among the guilts.

The mark of a unitary man is his recognition of the good and bad aspects of himself while retaining the ability to function usefully in spite of these incompatibilities. In addition, unitary man has the ability to contain acceptably within his tribe persons who are prone to show those deviant aspects. As examples of this, modern books have discussed the mistresses of Presidents (Jefferson, Lincoln, Franklin Roosevelt) or the mental illness of other leaders (Joe McCarthy, Forrestal, Churchhill, Wilson) and even after the great scandal of Watergate, people were able to accept Nixon as a human being.

Total Body Memory

Unitary thought however does not consist in a mere intellectual integration of good and bad within the same person. Rather, I believe, there are two ways in which unitary thought functions:

(1) Unitary thought grasps concepts and perception with all the organs and functions of the human creature. For instance, a person may recall sexual intercourse in its details and be able to describe it categorically in a modern dualistic sex novel. But when actually participating in sexual intercourse, the person quickly realizes that the intensity and the subtlety of the perceptions and the emotions are something he has felt before but could not remember when he was trying to write about them. His whole body in the act of intercourse participates in generating the full memory and that memory returns to him only when the entire body is again a participant and puts together all the memories of all the organs. This is unitary thinking. The dualistic aspects of thinking categorize the experiences and may pruriently stimulate fragmented desires and pieces of imagination. But the full perception and even the full memory of a complex, total body-and-mind experience is available to the individual only as a unitary person, not as a dualistic person.

Similarly, a violin player may understand intellectually where to put his fingers to play properly. But his skill in actually executing good playing rests in his fingers and not merely in the verbal, visual or even tactile categories of his knowledge. The fingers themselves contain part of the knowledge. It is only when the violinist, as a whole person, including fingers is actually playing the violin that he recalls fully in his consciousness the entire meaning and sense of the playing. When he is not playing; the skill and the habits remain in his unconscious and are unavailable to him.

(2) A second aspect of unitary thought is a sense of self depending on and consisting of membership in a group culture. The self is part of the group. Simutaneously the group is contained within the self. For the self includes all the roles which the group includes--all the styles

> of language and all the methods of conceptualization. Indeed, the individual self may include two incompatable groups as when a Tibetan individual becomes Westernized. Between the true Tibetan and the true Western culture in their two parts of the world, there is little understanding, little communication, little charity. Some idealistic individuals of course do maintain the illusion that such understanding exists. Between the two cultures contained within the Westernized Tibetan individual, there is also little communication but the delusion is lacking. This individual knows he cannot act nor think the same among Tibetans as he can among Bostonians. Thus, the Westernized Tibetan may contain within himself a unitary Tibetan self and a dualized Western self.

The last dozen paragraphs have spoken in a way that most dualistic minds would consider ambigious, inconsistent and even chaotic. They speak of opposite feelings existing at the same time in the same person and available to his intuition. They speak of a self as only a part of a culture and yet at the same time a culture as only a part of a self. They speak of both social groups and individual human bodies as having memories of their own.

Psychotherapy

A dualistic psychotherapist may consider himself a member of an elite class loyal to a well-studied set of ideas and assumptions tested scientifically and jelled into an established literature. He applies his expertise objectively to a patient who is not such a member, but who has problems the therapist can help. The therapist denies he himself has such problems; if he ever had them, he outgrew them. Standing aloof from any personal involvement in the problem, the therapist provides psychological manipulation, drugs, etc. Sometimes he "converts" the patient to an intellectual management of his problems; and the patient becomes an "associate" member of the group of intellectuals living in this ideal literacy-intellectual world of psychotherapy.

Thus, a patient economically retarded by a girlish ambition for stardom in the world of show business and gushing histrionically over the gemütlich music of 19th Century Vienna, might be led to an interest in the more stable kinds of work and social relations within her own society and that of the therpist. She would in effect "grow-up" and become a mature, self-confident working member of her own community.

On the other hand, a unitary person acting as therapist in this case, may well have seen the girlish enthusiasm as merely equivalent to enthusiasm he himself had felt in earlier life and which persisted presently as five percent of his own emotional day. He and the patient together would appreciate this histrionic emotionality and the joy of the approbation which comes from its public exhibition. Together, the pair would go beyond that manner of thinking and feeling until each was using any such feelings to provide mechanisms or energies to move onward more profitably in the social world. The therapist would then be both subject and object. So would the patient.

Most of the professional literature about psychotherapy still assumes that the therapist and the patient belong to the same culture and even the same social class. The lower class persons who become psychiatrists will often deny even to themselves that they were ever low class. They may become "adjusted" and integrated into an upper middle class. Their acceptance into that class with high prestige may be considered a sort of therapy for these professionals.

Similarly, foreign medical graduates from Korea, the Phillipines or Iran, for example, may become such good Americans that their foreign education give them no advantage. The unitary man however may unify two or three cultures or sub-cultures and produce a broader personality and broader skill in therapy. This unitary person may experience more painfully than others the cultural shock of growing up to an industrial life, becoming a part of a new family at marriage, or learning how people of "tribes" live and feel.

Goethe As A Unitary Man

Whyte considers Goethe the best example of a unitary man between the age of Socrates and the television age of the newly developing countries and tribes. Goethe did not create his work nor dream his vision in a monastic or artistic isolation. He lived, thought, politicked and reared his illegitimate child in open society. He lived fully the course of each of his theories, each of his human relationships. His life seemed to presage the development of a more unitary society in the centuries to follow him. Contrarywise, the lives of Socrates and Jesus outlined the forms of the dualistic life which were to prevail after them. Their philosophies envisioned a world of idea and spirit incompatable with, and separate from, the world of practical politics, marketing, entertainment and war.

Goethe's vision of himself was unified with mankind and with nature. Exemplified for example in the last fifteen minutes of Faust II,[17] it heralded a type of unitary man in the centuries to follow--a European man who would not need to convince himself that his thoughts and actions remained distinct from the world of men and nature. He would be able to think and plan intuitively as well as logically in the midst of the flow of events and actions which inevitably involved him. Goethe, himself, with malice toward none, had moved from one view of life to another and another, from one human relationship to another as he outgrew each inturn. As he metamorphosized himself from Urfaust to Faust II he participated in the changes in the social and scientific world around him. As he developed from Charlotte Buff who inspired Werther in his 30's to Ulrike von Levetzow who inspired the Marienbad Elegy in his 80's, he participated in the growth of the feelings and intelluct of those women. As a complete participant within each liason, he developed his own personality. Each member of his relationships carried forward to the best of that member's ability the destiny of a person merged with the social universe.

On Goethe's own side, he was always able to express each part of his nature in his scientific, artistic and social interests. His collection of "Conflicts and Previsions" was really a head start on Nietzche's later prediction that future generations would appear immoral because their natural resentments, cruelties and hedonistic indulgences would not be silvered over by pretenses or delusions--nor by the belief that the total self of the person contained only righteous feelings and impulses with all sin denied. Inwardly and outwardly this future person would live fully his many faceted self. For all persons contain offal though not all are constipated.

Like the dying Faust who participated in improving the agriculture and life-style of a whole people, the range of future man's behavior would conform to the necessity to improve others in the act of improving himself--for he

would recognize others as constituting an integral part of himself. To dualists of the century that followed his death, Goethe's life seemed particularly beautiful for two reasons: (1) he was an elitist who took the opportunity to develop himself to the fullest. He shined above others in a century when Adam Smith, Darwin and J. P. Morgan were convincing people that the fittest person was whoever survived--whoever made himself richer than others, intellectually, athletically, sexually or economically, (2) the aging Faust whose canal building opened up new transportation and irrigation, began a job-producing expansionist economy where vaster productions and consumptions were the key to high and virtuous civilization.

(In fact, waterways exhibited a burst of expansion in Goethe's own last years. A generation later, however, a burst of railroad building stopped the progress of the waterways. Later, still, a burst of automobile building halted the railroading expansion. Each successive transportation industry moved goods and people with greater fuel consumption, greater death rates and greater pollution, but with more jobs and more economic power to the new industry).

This content of Goethe's thought however contributed but a little to making him a unitary person. More importantly, his thought and feeling infiltrated all levels and ranges of European life. He absorbed many kinds of people and many ways of thinking into his intellectual and emotional life. Creatively within the social world of his day, he gave himself to those people and to those ways.

Implications for Psychotherapy or Business Management

If we ourselves, as therapists or managers, are acting and feeling within ourselves mostly as unitary persons, but if our clients or employees are dualistic in their thinking and feeling, then we need to recognize that their way of living is just as valid as our own and we can deal with it if we recognize its existence and its validity, its advantages over the unitary way and its disadvantages.

Furthermore, when a therapist faces a client and needs to make a diagnosis and catagorize that person in order that the necessary money and time and people can be allocated to provide proper correction of the problem, then we need dualistic kind of thinking. On the other hand, when we are asked as therapists to love a handicapped person--a retarded, schizophrenic, senile, smelly, violent person exhibiting only those "trace-quantities of loveableness" or perhaps displaying his "frozen crisis plumage"--as Norris Hansell would say--ah, then we must act as unitary persons. This takes unmeasureable and uncost-accountable intuition and feeling. Families, taxpayers and governments often want to stand aloof from these caring relationships, but to demand accountability for them--measurable in money, hours and number of therapists or clients. Those consumers and managers who are now unitary persons demand a unified service from unified persons.

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A Group-Psyche Model for Teachers of Community Psychiatry

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COMMUNITY PSYCHIATRY, to some psychiatrists, implies the doctoring of a community psyche and not merely the practice of psychiatry upon the individuals within a certain community. Here, I hope to make clearer the concept of a community or group psyche, which I have found to underlie much of the practice of both military and civilian community psychiatrists but which I have never found spelled out at length. My model, certainly, has no official type of sanction. I am sure that every community psychiatrist has his own variation. Neither do I suggest that this model substitute for the theories of individual psychiatry. I only feel that cognizance of two widely differing models and techniques of practice gives freedom to select some flexible third model most appropriate to a particular time and community.

Let's get progressively more definite. What is a normal human psyche? It is a system of closely interrelated human parts capable of improving its own organization in order to transact more satisfyingly with its environment. Examples of psyches are: a human individual, a family, an industry, a nation, a cultural ecumene. Now to build up the concept of community psyche let us turn first to the evolution model in biology.

Conceiving of evolution as based on the metaphysical principle of chance interactions in an excited field, we can assume that there were atoms in a primeval broth which slipped into protein configurations which were then able to reproduce themselves. A virus developed with DNA coding and we had life. Note that the underlying substance from which life was formed was a myriad of "dead" atoms. The living protein or virus can be seen as having a new principle—a life principle—which none of the atoms had by itself and which no mere numerical aggregate of them had.

Now, after a billion years or so of evolution, some species have developed a certain amount of culture. For instance, a tigress teaches her young in a traditional way to catch and kill deer. This knowledge is passed from phenotype to phenotype by communication between the individuals. After many generations, the old instinctive ways of getting food or building nests may, somehow, no longer exist in the genotype to be transmitted to the individual by the genes. Culture has to this degree replaced instinct. Some higher primates are now incapable of reproducing their species if the individuals are denied the necessary contact with the culture.[1] But, the culture—the socially transmitted traits of behavior—goes on

[1]Geoffrey Bourne (Yerkes Primate Lab., Atlanta, Ga.), "Primate Ethology," lecture delivered March 2, 1966, at Div. of Neuropsychiatry, Walter Reed Army Inst. of Research, Washington, D.C. Apes separated from adults when old enough to care for themselves and kept in isolated groups of mixed sexes became a problem to the Yerkes Primate Lab. because they could not reproduce. They simply did not know how. As soon as a sexually experienced female was brought to live with the group, reproduction began.

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and on in spite of the death of individuals who transmitted the traits. Some traits remain constant over centuries; some develop further. The culture, like life itself, is a principle quite apart from the individuals (or atoms) which were its substance. We psychiatrists are very interested in the culture carried by a group or individual. We are not so interested in the mere morphology of bodies.

The human culture (traits, traditions, mores), which developed a life of its own over the substrate of a group of Homo sapiens, is more elaborate than the culture of animals. This is true partly because languages developed out of communication efforts. The languages, like other culture traits, took on a life of their own, quite independent of the lives of men. Thus, for example, it can be predicted that in three or four generations, the traditional genitive case will have dropped out of the German language.[2] To ask what individuals will make this change is no more relevant than to ask what cells will decide to continue reading this paper (in spite of some threat to the self-concept). It is more appropriate to conceive of a mind as deciding to read and of a *language* as undergoing a change in its cases. Accordingly, we do not speak of an animal's life as residing in a cell, nor of a language's life as residing in a speaker.

The figure represents the Western culture-psyche of 1967. A sampling of culture traits is shown as if inside the culture psyche. Remember, it is continually developing. For simplicity, this diagram does not show how various groups mediate and modify the imprinting of traits from culture psyche to individual psyche.

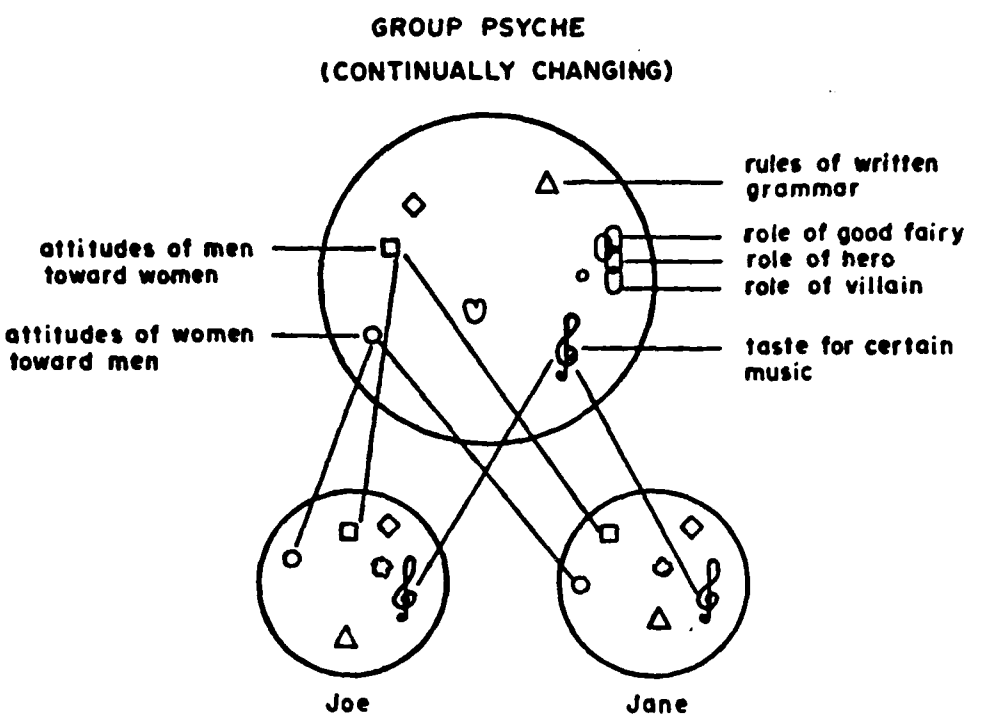
Theoretically, there is always the possibility of a one-to-one correspondence between the individual's traits and the culture's traits. A bit of the bank robber is contained in almost every person—not just in Jesse James. Almost everyone who sees Jesse in jail feels the psychological jailing of his own bank robber trait. However, a man who, by one means or another, has developed a lacuna, as it were, where his murder trait should be, does not enjoy a murder mystery because he cannot empathize with the murderer and therefore not even with the detective. Similarly, a therapist who, for any reason, lacks certain culture traits is unable to empathize with the corresponding thoughts and feelings of his patient.

If the culture's stock of traits and concepts changes, then the individual's stock also changes. Even psychotic behavior and thought content changes from concern about Hitler to concern about sputniks or poverty.[3]

If a group of people has a certain set of lacunae, or has a set of especially overgrown traits, we may say the group belongs to a subculture. Recently, both educators and therapists have become concerned with whether we should help the individual to fit in well with his own subculture or help him to adopt a general U. S. high culture. If the particular set of culture-traits imprinted upon the individual became nonexistent, he would consider his old familiar self as good as dead. Conversely, his usual behavior and feeling would face a deathlike inhibition if all his associates suddenly began to eat mostly fried cockroaches, cats, horse blood, and red toadstools, or to practice homosexuality, to speak only Etruscan, to enslave all blue-eyed people, to count by 2's instead of 10's, and to expect him to do the same things. He might indeed cry, "Give me my familiar culture or give me death!" Now he might not die

[2] Since the time of Goethe not only has there been a decrease in the use of the genitive case among German writers and speakers, but also, for several years now, there has been active in Germany a group which calls itself The Society for the Preservation of the German Genitive. This would indicate the genitive is in dire straits.

[3] Claude Lévi-Strauss found among different cultures a similar stock of myths, kinships, and ideas about flora and fauna, from which each culture formed its own special thought, categories, and customs. *La Pensée Sauvage;* Paris, Plon, 1962; *Le Cru et le Cuit;* Paris, Plon, 1964.



CULTURE-PSYCHE MODEL, WITH SAMPLE TRAITS

as a physical aggregation of cells; indeed, the cell-aggregation might go on to take up the new habits of eating, communicating, fighting, and so forth. Nevertheless, the old "me" would be dead. If he returned later to peoples and places of the old familiar culture, that old "me" could come back to life again and evolve as usual.[4]

So, what makes a group of atoms come to life? It "adopts" a certain organization. That organization continues although individual atoms are constantly exchanging themselves for others in the outside broth. The atoms are not themselves alive: They participate in life.

What makes a group of men a culture? The group "adopts" a certain set of traits and manners, ways of thinking and desiring, which continue although certain of the individual men emigrate or die and others enter the system by immigration or by birth. The individual men are not the culture: They participate in the culture.

There is no human psyche common to all men just because they are born Homo sapiens. The most complete psyche is the culture itself. When we speak of China, or ancient Egypt, or pre-Columbian Mexico, we are speaking of three distinct *culture psyches*. The nation participates in this grand culture psyche. The nation's set of styles, traits, and ways of thinking comprises

[4] Some cultural anthropologists in the field convert their manners and even their grammar of thinking to those of the culture in which they are immersed. For a description of some of the starker methods of changing one's culture and self-concept, see Robert J. Lifton, "'Thought Reform' of Western Civilians in Chinese Communist Prisons," PSYCHIATRY (1956) 19:173-195.

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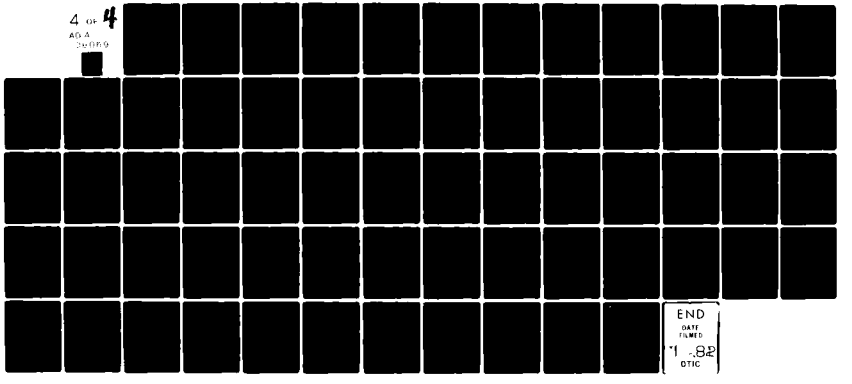

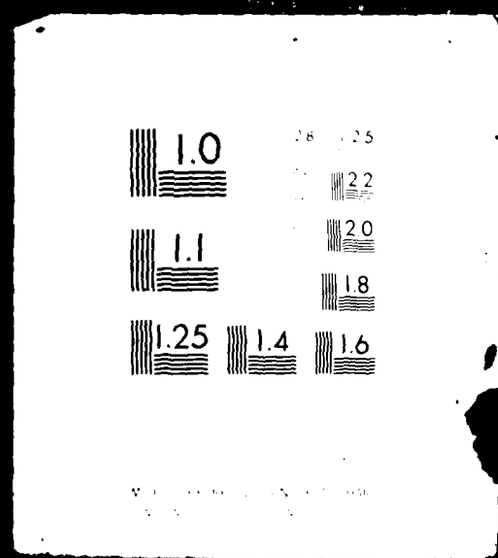

the *national psyche*. The town, the school, and the family similarly have psyches selected out of the nation and the grand culture psyche. The individual himself may be considered a central nervous system (CNS) which temporarily participates in a psyche from some group. His thinking is done as a member of such a consensual psyche. The individual usually participates, indeed, in the psyche of several groups. The psyche does not die. That part of the psyche which pertains to a particular moribund CNS may be redistributed in the total community psyche, different CNS's taking varying parts of it. The individual's traits and roles are either disseminated among many other people or transferred en bloc to a single other. This idea is a bit Brahmanistic but it fits community behavior.

What makes a certain man feel he is a person or a self? He is given by his mother, his teachers, his peers, a certain set of tastes and skills and way of thinking, and he is allowed to fill certain roles; sometimes he is *forced* to fill them. He sees himself as that particular set of traits filling those roles. His aggregate of cells is not an individual (as a person); it participates in an individuality. The individual is defined and molded and created by the social group which acts upon the aggregate of cells.

Day by day the psyche of an individual changes as the individual's behavior gets feedback from the ambient culture. In a rapidly evolving culture, an adult does not think quite the same this year as last year. In Western civilization—now a chain-reacting urban complex—not only does the son take up a different profession from the father, but also the individual may be forced two or three times in the same lifetime to change the way he practices his profession. Entire professions die, factories become converted. An adult has different self-images according as he is promoted or demoted, or finds a new profession, or as he marries, or goes to jail, or to a hospital, or to a vacation resort. If his group develops a generally paranoid attitude toward bosses, he is likely either to do the same or to spend considerable energy doing the opposite. In either case, the group gives him a good many of his thoughts. If he has a good central nervous system and lives sensitively at the convergence of several important lines of communication in his group, he may discover or invent something original in that group. He will sometimes find at that point that some other man in another group, which is part of the same general culture, has simultaneously invented the same "original" work. The other man was subject to similar influences.[5] What, then, is the individual psyche? It is a participation in a cultural psyche. Ninety-nine percent of the organization of thought was done before the individual came into the culture. Practically every category of classification, every word he thinks, and every grammatical construction he uses, was there before the individual existed.

Now, let's take a specific case: Suppose that a particular child finds he gets most sympathy when he gets sick or is injured. Later, as he moves into the group of his teachers and peers, he outgrows this behavior and functions quite well. As an adult he gets into the Army. He finds himself in an infantry company with an average commander; but the company feels the commander is being too hard on it. Speaking through the mouths of its members, the company says, "How can we stand it? Somebody is certainly going to crack up under this strain. I wonder who. It's enough to make you want to kill yourself." After a time, our young adult gets an "original" idea. He can't stand the "harassment" any more. He'll cut his wrist. So a part of an individual

[5] A. L. Kroeber, *Anthropology;* New York, Harcourt, Brace, 1948; the clustering and nature of genius, pp. 336-343, and the meaning of simultaneous inventions, pp. 365-367. Leslie A. White, "The Locus of Mathematical Reality," pp. 282-302, in *The Science of Culture;* New York, Grove Press, 1949.

shows up in the psychiatrist's office—the part playing *this* role at *this* time. The soldier is in the office as a part of a group, a part of a culture. Indeed, he is a part of the psychiatrist, since a sensitive psychiatrist is part of the community he serves. The psychiatrist is professionally coexistensive (if I may coin a term by condensation) with his culture. It is inside him and he is inside it. The community-oriented psychiatrist knows that in this case if the company had found a member who had in the past relieved himself of some problems by actually cutting his wrist a couple of times, then that member and not this present one would have become the medium of group communication.

These ideas are not intended to destroy the concept of the individual, but to strengthen it. If there are ideas of our minds which we have considered peculiarly our own, but which are really the group's, the language's, the culture's, then when we realize where these ideas really come from, we will be left with further understanding of what is truly our own. The self will be less than we used to think it was. But perhaps standing in that new knowledge, it can be freer and more individually autonomous. It was painful for Western man to accept with Galileo the idea that the universe did not revolve around him, but it was only this kind of acceptance which put him in a position to be an astronaut. If we can now explore with Harry Stack Sullivan "the illusion of personal individuality,"[8] if we can determine more of what the individual is *not*, we can release the individual to utilize better his culture, his community, and his central nervous system.

Traditional psychiatry has seen the individual as a slave to his personal history. Environmental influences in early life are seen as causes of later psychiatric symptoms. But now we understand that today's influences constrain the patient to emphasize and select certain half-forgotten aspects of his history which fit in with today's problems—which sometimes even solve them. A patient's history is not merely something that he has lived in the past; it is also a myth that he develops out of his present interaction with his psychotherapist or with his family or with his work group. Sometimes a parent gives a teenager a new history by telling him that he was adopted. The assumed or imagined history is just as powerful in influencing present behavior as are the real events of the past. The "First Families of Virginia" are generally proud that they are descended *from* English gentry, and they act accordingly with considerable decorum and social responsibility. Actually, many such families were descended not from English gentry, but from indentured servants who went into slavery for a number of years in order to repay their fare to America. In a few generations, however, they amassed both land and family myths, and they behaved according to the changed "tradition."

A man from India who moves to the United States inherits the Fourth of July. He celebrates it like any other American. It becomes a part of his cultural past just as if his ancestors had invented it. A history, then, like any other legacy, may be passed on from one person in a present group to another in the same group.

A psychiatrist will be impeded in his development as a community psychiatrist if he has too narrow a concept of the self, and believes that it is something which is enclosed in a single, skin wrapping. It is said, for instance, that self-preservation is the strongest "instinct," yet a mother may give up her life in order to save her child and thus to keep her own proper role in the family. A soldier may charge up a hill to certain death when he could have stayed behind and perhaps only gone to prison or the hospital; but he must

[8] Harry Stack Sullivan, "The Illusion of Personal Individuality," PSYCHIATRY (1950) 13:317-332.

charge up the hill in order to keep his membership in his *present* group. Self-preservation, then, must mean the preservation of some set of group mores and perceptions, and this set is certainly not bounded by skin.

Psychiatry's Field of Action

"Community psychiatry" is as redundant a term as "total psychiatry" or "general psychiatry." Why not just call it psychiatry? It concerns itself with cultures, institutions, groups, families, individuals; for all of these entities have psyches. It concerns itself with the developmental processes of all such systems, with histories as inheritable property and with symptoms as negotiable instruments; for all these processes have Aesculapian aspects. Individual clinical psychiatry is an organic but rather restricted part of "community" psychiatry.

Community psychiatry starts with the community—not with individual clinical psychiatry. The community psychiatrist sits in on the planning of political and commercial enterprises—schools, prisons, housing developments, factories, churches, educational demonstrations, and disaster rescue operations. In some communities he may have little contact with any patients, for indeed his relations with the community come first; and primary prevention comes before secondary.

The psychiatrist is part of the community—not set apart from either patients or politicians, not even set off as a unique consultant. He adds his expertise to the mental pool that is the planning community. For a spell he may play a bit part on stage, but he reverts to the community audience, which also constitutes the troupe. In family or group therapy, or in a community council, he usually sits in the group as a member of the group. By alternating between action and observation, he stimulates others to do the same; and more importantly, he contributes to the entire group's effective evolution. In each group he acts differently. He changes his self-image at least slightly with every new group he is in. All therapists do this in any sort of therapeutic situation, but a community psychiatrist suffers less pain with these identity changes because he knows his identity depends in part on the present group. Psychiatrists who are oriented purely toward the individual sometimes cling to the idea that they must have a single, lifelong, adult identity, and this makes them too inflexible. They are afraid to get out of their white coats, their offices, their psychiatric language, and go into a home, a classroom, a neighborhood, behaving as a guest-member in the appropriate language and mores of the group, and yet bringing in some different memories and manners.

Today we see the self as developing by transactions. Transactions are seen as occurring across boundaries. We form boundaries around certain sets in order that they may transact with other sets. We put boundaries around doctors—license them, let them develop a language of their own—and they then transact with patients, with legislators, courts, schools. But as appropriate in the transaction, we vary the permeability and inclusiveness of boundaries. We now generate new professions (e.g., nuclear physicists). We change old boundaries (e.g., between master and servant, hospital and housing area). If psychiatry as a profession changes, then *nolens volens* the individual psychiatrist has to change.

Why don't we come up with some easily understood and easily taught techniques for community psychiatry? The answer is that no large civilian group has been practicing it long enough to develop a lore and a language about it. Neither in surgery nor in psychoanalysis did therapeutic techniques grow up rapidly. Read a case study in a psychoanalytic or surgical journal. Does such an article tell you the technique of how that case was worked out so that you could do it yourself, even if you had never had

experience in that specialty? Or does a study of music books enable you to play second violin in a string quartet? While reading Freud does not make us expert in the technique of psychoanalysis, it does help us to accept the concept that parts of our psyche act outside of our awareness. This is an essential first step in psychoanalysis. The concept of the individual as a precipitate of the group is a first step in community psychiatry.

Some of us, however, do know something of the practice of community psychiatry. Why can't one of us jump right into a community and start practicing? This is analogous to the surgeon who tries alone to introduce aseptic surgery into a jungle tribe. He finds it difficult to get a team organized around aseptic surgical concepts, for no one in the jungle has any anxiety about dirt and germs, and there are no ready-made rituals to guard against them. On the other hand, it is no great accomplishment for a mediocre surgeon to move into a modern hospital and start operating, for he simply finds that he is automatically a member of an already well-functioning team of operating room and hospital management personnel.

The Effect of Conceptual Models

Any traditional psychiatric case that is presented, for example, in a Kraepelinian descriptive model can be translated (usually after some further investigation) into a psychoanalytic model. Treatment in terms of the new model will usually be effective. The same case can be further translated into a nonindividual model, but after such translation it often does not appear that any individual patient should foot the bill for the indicated community type of treatment. Hence derives one strong resistance to the nonindividual model itself. Treatment in the nonindividual model may involve the cooperation of several segments of the community power structure—educational institutions, police, social welfare agencies, legislative bodies, medical services, local group pressure or aid, and so forth. A presenting symptom may be relieved by (1) getting several symptomless people to readjust their way of behaving with the symptom-carrier, or (2) reeducating several symptom-carrying people so that they do not merely make an adjustment but actually accumulate more knowledge and skill, or (3) reacculturating these same people and perhaps a whole segment of the community so that tastes, ambitions, and styles of living change. Now, such work with a community always involves action by more than one discipline. This makes it foolish to try to understand psychiatry by studying only psychiatry. Its very existence as a coherent system rests upon outside systems.[7]

One may practice individual psychiatry by fitting oneself into a circumscribed role set by the community. But in such a role, one has little ability to effect broadly the mental health of the community, taking into account the influence of migrating industries and ethnic groups, of changing business practices, police and educational methods, city planning, tax allocations, and so on. Such work requires the ability on the one hand to identify oneself at least temporarily with lawyers, business managers, and educators, and on the other to utilize the local community's direct tribal relations, its bartering, its superstitions, its vendettas and the warmth of its face-to-face transactions. The use of a group-psyche model which also includes the concept of the individual is far less constricting in such work than is any traditional individual-psyche model.

If modern psychiatrists avoid thinking and practicing with a community psychiatry model, then they may actually produce that chaos which accompanies poorly organized revolutions.

[7] For the mathematical proof that there can be no system which is self-sufficient or entirely consistent internally, see Ernest Nagel and James R. Newman, *Goedel's Proof;* New York Univ. Press, 1958.

They would produce it by blocking the course of natural metamorphosis for community psychiatry within the medical tradition. As the changed social needs arise, the unchanging psychiatrists might give their natural responsibilities into the hands of more socially oriented professions. At the same time, they might deny those professions any easy way of unifying the warm physiological sensibilities of human encounter with the cool objectivity of institutional science and organizational role behavior. The addition of a group-psyche model to the concepts presently used in practice should help psychiatry to stay with today's needs.

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#44

THE CHANGING FIELD OF ARMY PSYCHIATRY*

Colonel Matthew D. Parrish, MC**

I'm supposed to talk about the status of Army psychiatry, but I can see no status in the sense of standing still anywhere. Army psychiatry is constantly becoming something different. In order to see it clearly we must look at it over some stretch of time. I'll try to conceptualize the developments over the past 12 years. For it was in the mid-fifties that it seemed to me our psychiatry stopped concerning itself exclusively with sick individuals. Attempts to change the symptoms in natural working groups, social organizations, and their responsible managers were up to that time the practices of a few selected psychiatrists. Social workers had been pretty well seduced into becoming junior psychotherapists rather than becoming men who dealt with social institutions. First, let's look at the changes in inpatient psychiatry over those crucial years, then at the mental hygiene services, and finally at combat psychiatry.

INPATIENT PSYCHIATRY

Milieu Therapy. In the summer of 1956 the milieu ward was opened at Walter Reed Army Institute of Research. The ward was seen as a pre-planned social and architectural climate into which patients could be inserted for a certain degree of improvement and then extracted from the ward to be reinserted into normal military society. The entire milieu staff was considered responsible for the improvement of the entire patient group. Corpsmen wrote extensive notes on patients. The corpsmen's interactions with the patients were considered therapeutically crucial. In its mature form the ward was by no means a place to house separate individuals with their unrelated problems until the psychiatrist could cure each one. Nevertheless, it was considered that the ward was maintained entirely for the sake of the patient and that the patient did all the changing--not the staff, not the local community. The staff got experience and training; the community got service.

The Therapeutic Community. At other places, certain wards have attempted to become "therapeutic communities." They followed a U. S. Navy model which in turn was derived from the British Army model of Dr. T. F. Main. The patient was considered to affect his environment as much as it affected him. Patients made improvements in their own environments and in methods of treatment by using their own ideas developed in council. The strongest direct influence upon an individual patient was usually not the staff at all but other patients. Very seldom has an Army psychiatric service become a true therapeutic community, however; for the staff still tends to wear whites and takes other measures and attitudes to insure that patients are made to feel like sick men. Two examples where the staff-patient boundaries have been more humanized are the KO team at Long Binh, Vietnam, and the operant conditioning ward at Walter Reed.

*From Army Social Work, Collected Papers of the Symposium on Current Trends in Family Therapy, 23-27 Sep 68, Fitzsimons General Hospital.

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The Long Binh Psychiatric Treatment Team has about 18 beds, most of the patients are acutely psychotic but there are no locked doors nor isolation rooms. The nurses, patients, and doctors all dress in the same jungle fatigue uniforms. (Only med-surg patients wear pajamas in the daytime.) Corpsmen write patient notes. There are frequent meetings of the total staff and patient group. As for work therapy, at first the better patients were farmed out to clerical or other jobs in the hospital. But this left the agitated or retarded patients back on the ward. Accordingly, all psychiatric patients were induced to work on a single project as a group. Still the sicker patients did not work during the time allotted. Finally, the group was given a task and told that if the task was completed ahead of the allotted time, the members could loaf or play. At this point the sicker patients joined in to get the work done faster. There is an element of operant conditioning on the ward because this system is purposely structured so that behavior produces certain dependable rewards and punishments.

Walter Reed's operant conditioning ward (108) uses a point or token system of rewards for a group of patients who were all considered character and behavior disorders on their way to separation for poor or deviant performance. All are eventually restored to duty and most have done adequate work. The patients are not called "patients" but "soldiers." They wear uniforms just as the staff does and they are expected to act like healthy people.

In Korea also during the conflict, psychiatrists found they could restore to duty more quickly those patients who were kept dressed in their normal uniforms and given some sort of military work or exercise every day. Nevertheless, most treatment facilities now stick to the white coat, the pajamas, and the "You're too sick to be a soldier" attitude. Some psychiatrists believe that a hospital is supposed to encourage patients to regress for a while before they strengthen themselves. As with med-surg patients, this regression, this relaxation into the arms of the nursing staff, is considered a part of the treatment regime. Other psychiatrists believe that in psychiatric patients, regression is indeed the illness and not part of the cure.

The larger Class I hospitals, like those at Ft. Dix and Benning, have lately been containing almost all their psychiatric patients within their own post--not sending them to Walter Reed, Fitzsimons, etc. for final treatment and restoration to normal civilian or military life. Recently when a psychiatric patient left Ft. Benning and went to Walter Reed on his own, the chief psychiatrist from Ft. Benning came immediately to Walter Reed and took the patient back for final disposition at Ft. Benning. In bygone days, if a patient ever got to Walter Reed, everyone considered he was at the best possible place for treatment. We all have known for a long time, however, that the social causes of his dysfunction and the resources for his rehabilitation lie much more likely at his local post than in any distant great hospital. Normally, the large Class I hospitals maintain a couple of hundred psychiatric beds for evacuees from overseas.

Partial hospitalization. There have been several ventures at day or night hospital management of inpatients. Most successful has been Tripler General Hospital in Hawaii. A good part of the day hospital program is managed by occupational therapy in a remodeled house. During 1967, essentially no dependents

in Hawaii were given 24-hour a day hospitalization. Married soldiers who lived in Hawaii were also managed with partial hospitalization. The only routine 24-hour patients were those who came from outside Hawaii. This is an extensive and therapeutically very effective program. For the details of how to start such a program, and how to get adequate work credit for patients hospitalized only part time, I suggest you write to Tripler.

Psychiatric Nursing. For over two years now a psychiatric nurse on the consultation service at Walter Reed has participated in group and individual treatment as a nurse--not as a substitute doctor--and has made home visits especially with family problems. Hopefully, our psychiatric nurses can help improve the social system which is producing the patients. In civilian life, for instance, some psychiatric nurses trained in operant conditioning go into a home and show a family how to manage a retarded child who otherwise would have to be institutionalized.

COMPSY. Psychiatric records at Walter Reed are slowly being computerized, and this will probably extend to several Class I hospitals which feed patients into Walter Reed. This system will allow the retrieval of data never before available, data very useful for therapy and teaching. Example: What percentage of Dr. Jones' patients were diagnosed as manic depressive? What kinds of treatment are most effective in Dr. Jones' hands? How does the patient's behavior on return to duty correlate with the type of nursing care he demanded?

THE MENTAL HYGIENE CONSULTATION DIVISIONS

Coordination of MHCD and Hospital. On post, the psychiatric ward of the hospital remains in practice an arm of the MHCD; for it is MHCD which works with the units, the families, the schools, the stockade, the housing areas, and understands the immediate meaning to the community of whatever patients and symptoms show up in the psychiatric ward. Army Community Services cooperates with MHCD by pulling in helpful volunteers, coordinating social effort, getting the community to help itself.

Off post many medical facilities have the medical area coverage concept (MEDDAC)--an idea borrowed from the type of coverage our Army uses in Europe. Direct specialty support is rendered over long distances. Psychiatrist and social workers may travel 100 miles in Europe to make a routine visit to an outlying base.

In any mental hygiene work all the therapeutic communities, treatment groups, classes or individual relationships built up in hospital and clinic are only in the service of the natural groups in which men work and live in the local community. These artificially formed wards, groups and dyads are part of MHCD's methods for getting patients back to living in their natural local groups, such as their families and units. The simplest and usually most effective method of doing this is simply to keep the individual in his natural group in the first place and then to work with that natural group to help it integrate the individual as a useful member. This is usually done by acting as a consultant to the leaders of such groups--sometimes by acting as a human communications catalyst within a squad or team meeting.

Psychiatrist as Staff Officer. Most psychiatrists are trained to work only with individuals they assume are sick. They do not see themselves as helping to plan and manage a whole normal community's psychosomatic effectiveness, morale, and mental health. In other words, most traditionally trained psychiatrists are not interested in doing the very thing that makes MHCD most effective as a preventive force. But there are two bright spots:

(1) Many social workers are trained to this sort of responsibility and if they do not become seduced into becoming junior psychiatrists, they can enormously improve a MHCD program. With a teen club, for instance, the psychiatrist is usually interested only in having individual conversations with the members or with small groups and then giving advice as to what sort of activities would be most healthy in the club. The social worker, on the other hand, is more likely to be concerned with balancing off the group pressures and personal ambitions among the various housing areas, school cliques, adult clubs, and local command needs so that the teen club remains integrated properly as to social class, race, sex, and sub-cultures. The club can thus affect all teenagers and they can affect the club.

(2) An increasing number of new psychiatrists are truly interested in the community psychiatry training they are getting in some of the residency programs and they work well in MHCD's.

Command consultation continues to be the heart of MHCD work. Units are visited by all types of MHCD workers. Conferences are held with command on unit morale, attitudes, symptoms. In some MHCD's, however, the psychiatrist almost never meets a commander in the unit area. These psychiatrists unanimously claim that to meet the commander in the clinic atmosphere or on the phone is just as effective as to go to the unit. Significantly, a few of these psychiatrists later begin to see and to know the commander as he works in his own unit. These psychiatrists then say they are many times more confident and effective in their work with command.

Prisoners. In the later 50's, psychiatry and the military police worked together so well that 4 out of the Army's 5 disciplinary barracks were closed, and many posts lost their stockades for lack of inmates. We seem to be entering another era of interest in prisoner rehabilitation or even prevention. At the moment, psychiatry doesn't seem to be contributing anything new to this. Many times MP's say in effect, "This prisoner has crazy behavior. Therefore I'm sending him to the hospital to get him out of my prison." The psychiatrist says, "He's not sick, so he's entirely a management problem for the MP's. I want nothing to do with him." One would think psychiatrists would be interested in the stockade since the behavior and talk of prisoners is one index of the changing styles of living. Many such styles are first evident among the dyssocial. Consequently mental hygienists of the past always thought it important for the psychiatrist to conduct daily sick call at the stockade, to interview at least a cross section of prisoners and to talk frequently with custodial personnel.

Training and Sensitivity. MHCD's have always conducted extensive on-the-job training and have participated in traditional lectures and demonstrations for other disciplines such as police, school counselors, nursing personnel. But nowadays they are also conducting sensitivity training courses for responsible members of the community such as chaplains, work supervisors, and teachers. These short courses are not concerned with salesman's tricks like the personality courses or business management courses of the 40's and 50's. They do not teach a personally detached manipulation of subordinates. Rather, these courses aim at developing a fearless you-me involvement by practical, secure supervisors.

Program Discontinuities. Frequently a good program in an MHCD has died when the chief psychiatrist or social worker who started it leaves the post permanently. Institutions should routinely outlive men. We still have to ask, How can we develop the kind of leader who can without jealousy maintain the continuity of the old leader's program? -- or the kind of leader who arranges for his programs to live after him? If your unit does this, please tell me.

VIETNAM

The strange thing about Vietnam is that the attitudes professional people have about it are mostly derived from the writings and the needs of people in the U. S. and not of people who actually work in RVN. The returnee who tries to correct these opinions soon finds his ideas so badly warped by his listeners that he begins to avoid those ideas himself. Mostly we are supposed to think that a year in RVN is a deplorable and unrewarding time for a doctor. It just isn't so.

Division psychiatry. From the beginning of the "escalation", division psychiatric service has been staffed and empowered better than in any other war. Although most psychiatrists would like to improve the organizational structure that constrains their social work specialists, still all the divisions have informally set up easy access for mental hygiene personnel to almost all command or staff elements and to good transportation by jeep and helicopter. Thus the division psychiatrist has the power to work influentially with a self-contained community of some 20,000 people--a sort of ability that most other military or civilian psychiatrists can only dream of.

Publications. The medical corps has its own professional publication in Vietnam--the USARV Medical Bulletin. In the past year it has published some 15 papers on psychiatry in Vietnam. There is a higher per capita rate of "grass roots" writing than in either the U. S. or Europe.

Relations with Vietnamese psychiatrists. Those of us who have worked with Vietnamese psychiatrists have learned a great deal from them. Not only have we learned new ways of communicating with patients and staff of another culture, but we have seen how families can manage the mentally ill without hospitals. We have seen how hospitals may weaken families by encouraging them to abandon responsibility. In the same community we can see what looks like a U. S. State Hospital of 50 years ago, and we can also see communities not yet "weakened" but still managing the mentally ill as we might expect the U. S. families and communities to do 50 years in the future. In Vietnam, thus, we may work with a developing profession and with developing communities.

Transcultural psychiatry. The Vietnamese psychiatrists are highly intelligent men who deal easily with the Western grammar of thinking and feeling as well as with an Asian grammar that most of us do not even know exists. American psychiatrists are likely to call themselves "transcultural psychiatrists" if they can interview middle class patients in two different European languages. Unlike the psychiatrists of Asia, they have little notion of the chasms of difference in thinking among cultures nor the real flavor of similarities among them. Transcultural psychiatry as one can see it in the Far East, seems to include as special understandings within it such things as various group therapies, psychoanalytic theories, organic theories, types of hospital management, family management, religious intervention, interfamily or intercommunity aggression, territoriality or status tension, several lores of drug usage, the mores belonging to people of various social classes, and so on. In the international professional meetings in Vietnam one gets the impression that what we have been calling general psychiatry is really a pretty narrowed down specialty within the wide field of human or transcultural psychiatry. Vietnam can strongly stimulate the American psychiatrist to widen his field of thought and usefulness in his own country--to work easily with more varied social classes, more subcultures, nomadic tribes, bureaucracies, family mores.

NARRATION

Vietnam as a Surgical Center

It appears that many new medical concepts are emerging from Vietnam but, in *statu nascendi*, they are hard to put in writing. As yet crudely analyzed, they are transmitted within Vietnam by preceptorship. This communication concerns surgery, but since I am not a surgeon and have only looked over shoulders and explored with surgeons their feelings and concepts, this viewpoint should not be construed as necessarily an official position of the army.

The three following myths seem to be passing into US surgical lore: (1) Every trained surgeon has attained for himself a certain unalterable standard of competence. (2) The best-trained surgical specialists in the world are coming daily to Vietnam to take over immediately, with high competence, the work of rotating surgeons, who have been a year away from the great centers of surgical knowledge and skill. (3) In the United States, there are a few training centers which vie for the world's first place in the surgery of trauma.

Any surgeon partially refutes the first myth as he compares his own work as a member of a smoothly practiced team with his results when working with a team not so skilled nor so well broken in together. The individual surgeon's effective standard of skill varies then with his team.

But can't we at least turn to the surgical *team* as the unit of competent surgery? Could we not send to Vietnam the best-trained team from the best center of trauma surgery in the United States and expect that team to perform better than any team already established in Vietnam? No, because the years of surgical experience in Vietnam indicate that such a team could not possibly practice with the same skill as a team which had already been in Vietnam for a few weeks. No hospital in Vietnam would now risk assigning such an intact team to operate immediately on its own.

But why is this so? First, the fast trip halfway around the world knocks askew the team's diurnal physiological rhythms. Members tend to get sleepy and hungry at the wrong times, to urinate more at night, less in the day, etc. They have to adapt to extreme heat, dust, humidity, and perhaps to oceans of water flopping from the sky, as well as to family separation and the nightlong shudder of buildings vibrating from artillery. But more important, they face the following professional problems, the like of which are never seen in the US surgical centers:

Strange Emotional Atmosphere.—Any team handles well a patient brought into its familiar operating theater, when the team is prepared. The team follows well all the principles it has learned. But put the team in a radically different theater with a new sense of urgency, a new emotional climate, and then it no longer acts as if it is so well trained. After the Worcester tornado in Massachusetts, there were some 350 major contaminated wounds handled by competent surgeons, who had often taught others never to suture contaminated wounds. The day before the tornado, some of the surgeons had probably handled such wounds very properly. But these surgeons are reported to have worked heroically all night, closing up 350 contaminated wounds. This situation is by no means peculiar to Massachusetts nor to mass casualty situations; it happens to some degree in both civilian and military practice whenever teams are working in a completely strange atmosphere. An individual or a team acts as if it had different training when it works under different environmental conditions—in isolation from familiar cues, with the senses flooded with new climatic, linguistic, or mechanical surroundings.

High-Velocity Wounds.—Wounds inflicted in Vietnam usually require more extensive debridement than wounds of any former wars or conflicts—much less the low-velocity gunshot wounds one sees in US city hospitals. Wounds incurred in Vietnam are very deceptive to the surgical team which has not worked with them before.

Severe Wounds.—A helicopter, minutes from an ambush, may set down beside the operating room a patient with high traumatic amputation of both thighs. He is still alive. Such a patient in the United States almost never reaches an operating table. An inordinate amount of major vascular surgery, neurosurgery, and severe burn management becomes routine. One day, for instance, the 400 Med. 12th Evacuation Hospital performed five major vessel repairs, but each operation was performed by a completely different team in the course of other extensive surgery. Only autogenous vessel grafts were used; plastics aggravate problems of infection in war wounds. A similar hospital performed 50 craniotomies in eight days.

Simultaneous Surgery of Multiple Body Systems.—A single patient may have severe wounds of the head, chest, abdomen, and extremities. The questions arise—how many surgical teams can work on the same patient simultaneously? How long should a team work on one part of a patient before some other part then assumes a higher priority? What sort of anesthesia is best for a patient with head and chest wounds and who has a tracheotomy and a severely burned face?

Mass Casualties.—Once, when the enemy disrupted the medical-regulating system, 40 unannounced patients were dumped on a 1,000 bed hospital in Japan. The surgical consultant from Vietnam could only remind the overworked personnel that the 120-bed, Second Surgical Hospital had admitted 160 patients in one day—all unannounced and all surgical emergencies.

New Hierarchy of Medical Communication and Transportation.—The coordinated treatment of a wound begins with the death-delaying first aid given by field technicians or doctors at the site of injury—the hemostasis, the immobilization, the tracheotomy, the beginning of blood replacement. The medics in the field are extensions of the hospital surgical team. They consider that they are preparing the *patient for immediate surgery. The* helicopter is their guernsey (a wheeled litter used to move patients from one part of a hospital to another). Not only does a chest wound affect the priority of extremity wounds in a single patient, but medical organization in Vietnam is rapidly coming to the point that every new wound on the battlefield, the minute it occurs, *changes the priority of every other wound in the whole country.* If several patients with wounds of moderate severity are awaiting treatment at the nearest surgical hospital, then a patient with a more urgent wound may be programmed in ahead of them, or he may be evacuated to a more distant hospital with a clear operating room. Because of air ambulances and on-the-spot field regulators equipped with radio, the surgeon feels himself a part of a well-oiled, countrywide machinery. He is not just the private doctor of a single patient, though he remains that also.

As far as the history of trauma surgery is concerned, the surgical team in Vietnam lives on the edge of tomorrow. Civilian pickup and management of traffic injuries, for example, has not yet caught up with the management by the military of trauma in the old Korean conflict, much less in Vietnam. In all history, there has never been a school of trauma surgery to equal Vietnam. But this school does not merely train individuals. It trains

teams integrated with their environment. The well-trained US team setting to work in Vietnam would find its postoperative morbidity very high. After two or three weeks of intense practice, this morbidity would drop to the level of other teams already experienced in Vietnam surgery. (A surgical week in Vietnam contains a month of experience.) The team which is expert in the surgical problems of Vietnam comes into being only in Vietnam. It is an integral part of the climate and the medical environment. That is why it is no longer usual here to install intact any new surgical teams from the United States. The army in Vietnam substitutes new members one by one into teams already practicing well in Vietnam. The integration of a new member, say a scrub nurse or a surgeon, causes tenseness and some over-alertness in the team, but it does not significantly affect patient morbidity. The team and the environment capture the new member, force him to "get with it." In a week, the team is as smooth and relaxed as it ever was with the most challenging surgery. This capture of a member cannot be effected by reading or by lectures. There is a whole social and environmental atmosphere to be absorbed. The member gets the hang of it; he does not merely analyze it intellectually. Thus members come, members go, but the team-environment system in Vietnam keeps on developing and improving.

Now we can go back and revise the three surgical myths stated earlier. The new assertions should read as follows: (1) A surgeon's skill and his follow-up record depend not only upon the team of which he is a part, but upon the social and professional environment in which the team practices. (2) The military services in Vietnam are *sending* to the United States the world's best-trained trauma surgeons. (3) There are several surgical centers *in* Vietnam which vie with each other for the world's first place as a training center for the surgery of trauma. But since surgery in Vietnam is so coordinated and interlocked—with easy shifts of professionals and patients—it is impossible to pick out any one center. Vietnam is itself the center.

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MARATHON GROUP TECHNIQUES AND THEORY

Matthew D. Parrish, M.D.

INTRODUCTION

This paper deals with how large groups behave when they are kept impacted in a small space for more than 24 hours and with little coercion from a staff. The group might be meeting for social encounter (e.g., marriage or business marketing), education, psychotherapy, recreation, research in group dynamics, or any other purpose.

Since 1952, my colleagues and I have participated in and led many traditional group methods of education, treatment, etc., but since 1965 we developed a polar extreme of marathon group. It is group-oriented, not individualist. It is developmental or educational in its emphasis, not therapeutic nor promotional. It is cross-class and client-staff integrated, not elitist.

Unlike some so-called marathon groups which really only last a few hours and have five or ten members, this group allows members to grow tired together, eat and sleep together, and meet where already familiar architecture can, in a sense, become an influential member of the group.

INDIVIDUATION FOLLOWS GROUP FORMATION

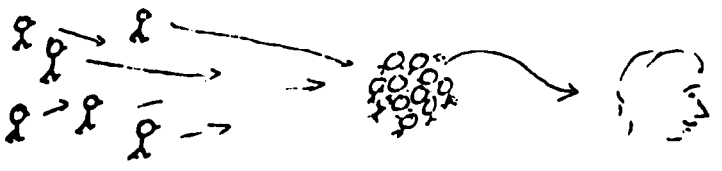
If the reader is not careful to look deeper, this paper may seem to sacrifice human compassion and personal autonomy in favor of a mass group progress. Or it may seem to neglect individual needs. But the very opposite is its intent.

Indeed, if we doubt, as far as possible, that there is any individual human soul or mind guiding the behavior of man, we will only come to see most clearly just how much soul there really is.

For example, if every member of a group happens to be named simply Pat, then all name prejudice vanishes. The members face in each other traits more peculiarly personal than names given them by someone else. They are forced to probe more deeply than the name. If we "dehumanize" every member by calling him Pat, or even by giving him a number, then we are forced to see that any name does not really differentiate us out from other people, nor does it make us more intimate and understanding with each other. Uniform dress can have an analogous effect.

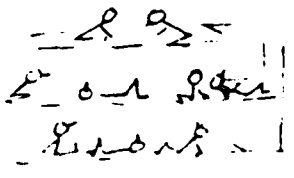
If soldiers or policemen all seem the same to us, then perhaps we are defining them by their uniforms or by some stereotyped parts of their behavior. We are not looking at the person.

The type of marathon group described in this paper provides experience with group implosion in emotional space-time, and yet provides personal individuation out of the group matrix. Without a useful group no useful individual develops.



SIZE, TIME, SPACE

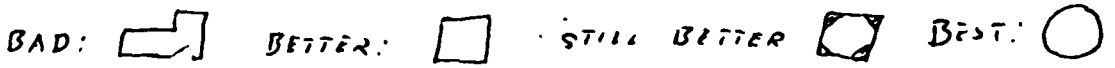
The number of members in this kind of marathon can range from about 15 to about 30 persons. Such a size not only allows all the major roles of the urban life to be developed, but each role can be understudied and there will be enough onlooking members to provide the mass role of an audience. Roles can be shifted, individuals can move from audience to "on stage." A group of less than 15 is generally not flexible enough for this. A group of more than 30 might have to be arranged on a three-dimensional net in order to provide communication of each member to each other member.

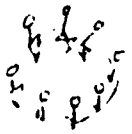


The duration of the group session ranges from about 24 hours to about 36. Less than 24 hours does not permit the group to go through a full cycle of daily life. It does not allow fatigue to move people into unguarded and differently perceived ways of behaving. The normal individual defenses which are usually maintained through the ordinary one- or two-hour group session cannot be maintained for 24 hours.

The group generally breaks up for about 45 minutes of stretching and strolling and small group formations around meals. Some groups do not break but exchange bag lunches or have food trays passed in. Individuals otherwise leave the group only to go to the bathroom.

Triangular prisms of wood or furniture sometimes block out the corners of the room. Otherwise there is no furniture. The more nearly circular the room can be, the better. If there is a deep corner, someone will retreat into it and partly evade the group. Many treatment groups, of course, work better if the patient can partially withdraw from the group. But I am not describing that kind of group.



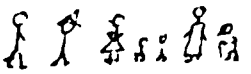


The meeting room allows no more than eight square feet per individual. As a rule of thumb, each individual is given one-half of a small single bed mattress. The floor is completely covered with mattresses. If there are a few square inches of bare floor anywhere, someone's elbow will be ground onto it during the night. The group should be so impacted that it is impossible for all the members to stretch out on the mattresses without overlapping or touching each other. Thus, a room 13 x 13 feet would hold about 20 people. This impaction requires adequate temperature control and good ventilation.

Smoking and coffee or cocoa drinking are continuously permitted. Candy and fruit may be brought in. Plastic ashtrays and a small wastebasket are useful. Every member brings a pillow and a blanket. A few extra pillows are handy. At night, the lighting is made dim enough that it is difficult to distinguish

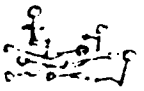
facial expression. This emphasizes different modes of communication. Sometimes members regulate colored lights in order to support a mood.

Members may sleep at any time but the sleep is considered a kind of communication to the group and may be dealt with in any way the group chooses. Emotional experience develops a greater range if the group is heterogenous with regard to age, sex, race, education, type of work or profession. The group recognizes there are other races besides black and white, there are other ages besides teenage and adult. There are other classes besides the middle class.



VALUE OF THE GROUP TO VARIOUS SOCIAL CLASSES

Apparently the suburban middle class intellectual has so isolated himself into nuclear families, specialized professions, and retail economies that he feels a great need and desire for marathon groups once he discovers them. The non-intellectuals, on the other hand, and the extended families of Southern Europe or of black southern United States, the rural peoples and the smaller religious denominations find the marathon group already in accord with some of their natural everyday behavior. It does not fascinate them and they have less apparent need for it.

STAFF STRUCTURE 

At any one time, at least two staff members are awake--members experienced in marathon groups. Three would be required if any one of them is to sleep during the session. A common staffing is two highly experienced staff members and two with more than one marathon experience plus some additional theoretical understanding.

An additional staff member always acts as a sort of circulating nurse who has contact with the outside world and protects the group from direct intrusions by the telephone, the door bell, minor emergencies, food arrangement, etc. Often a staff person merges completely into the membership but all staff do not do this at the same time. There is always someone sensing the movement of the group as a whole.

ECONOMICS

The marathon group is a tribalistic phenomenon. It is not individualistic. It develops more completely, then, as a group phenomenon if the staff is not paid by individuals nor in the name of any individual. The staff, if it is paid at all, is best paid by a group, a club, an institution, or an office. The prime staff motivation is the fun of collective teamwork and responsibility and the sense of aliveness that comes in a working group. If this is lacking, nothing can compensate.

GOALS

1. The marathon group may provide for an institution or for a scattered local profession a feeling of close understanding, so that it can work more productively. For example, the group may comprise the staff of a hospital or all

the school counselors of a county. Particular care is taken to avoid getting involved in personal history of the members when the group consists of people who naturally work together every day. Concentration upon the "red herrings" of the past (such as what an absent husband said to a member last night) will not only prevent progress in the here-and-now relations among the members but it will disrupt the group as a currently productive working organization.

Good group development can occur in a contrived group of variegated professions, races, ages, classes, which forms a small, one-time culture with its own micro-history. But if even this group is to avoid remorse and perhaps blackmail or slander after the session is over, it concentrates upon the current relations between the members as they occur within the group session.

2. The marathon session develops the potential of the group as a whole. Such a group is like a ship's crew which moves as a social organism over the ocean toward the ship's goal. Various crew members might want to go to various inland towns. One or two members may even abandon ship, but the crew's task is still to move the whole ship, not the individual crew member.

3. Individuals may aim at learning how to manage group dynamics. But only when a member furthers the evolution of the group as a whole will he best gain in his ability to predict and control what any groups may do. He will understand by personal experience what people feel in groups, even though they may not realize they feel it. He will certainly also get the best understanding of himself as a group member.

The skills developed in the marathon are not especially valuable to the person who considers himself an individual in isolation rather than as constantly a member of a group.

The marathon group as conceived here never aims at curing individual illness nor emotional problems. Such benefits do develop but they are incidental by-products. The same benefits may also result from classroom instruction in chemistry.

CONTENT OF GROUP BEHAVIOR

Since the essential content of the group behavior is non-verbal, no gimmick is necessary for "starting" interaction among the members. The group is always in motion from the time it gathers together until it breaks up. If it is sitting around and saying nothing it is nevertheless interacting. Gestures which are not interpreted nor commented upon are nevertheless gestures with content and meaning. Indeed, other gestures make the comments and interpretations. Staff can, of course, bring the group to carry out some psychodrama or other developmental work, if it is appropriate to the current phase of group life.

The group makes a special effort to concentrate on what is happening in the here-and-now of the group itself. It avoids bringing in verbiage about yesterday's happenings. Other groups often concentrate upon the past or the distant future because they fear an encounter with the here-and-now. Such inappropriate verbiage tends to pass the time so that nothing can come of the here-and-now encounter.

It is very common for an effective marathon group to end without the members knowing the last names, the professions, the educations, or the local origins of the other members. Yet all the members may understand each other more intimately as unique persons than people who categorize each other so well in everyday life.

This avoidance of the past as well as the future may sound strange when we remember that the meaning of any gesture is derived in large part from tradition. Thus, an English word spoken in the group derives its meaning from the well-established English language. Members enter the group with perhaps crippled hands and feet or with special skills, all of which are derived from the past. In the marathon group, however, we are mostly concerned with what these assets or liabilities mean in the interaction between the people in this particular group session. Even English words may develop a special contemporary meaning within the group session. The group may invent words for itself.

CYCLES OF EMOTIONAL EXPRESSION

Large crowded groups which eat and sleep in the same small furnitureless room for 30 hours or more can usually be seen to express their emotions in five stages. These stages proceed essentially in a cyclic course, and if the group lasts long enough a cycle may recur once or twice.

Completely different patterns of emotional progression, however, can be found if looked for. They may be just as valid as this one. If in your groups you find a pattern more useful to you, then you should look for it in subsequent groups. You will usually find what you look for.

With several old clients and staff members I reviewed our experiences after a dozen 30-hour marathon groups. We found that almost all of our groups had developed a five-stage cycle. Some of them had not reached as far as the fifth stage. Others had gone on into a second or third cycle. After this discovery we went on to do more marathon groups and confirmed our discovery. Typically, the cycle proceeds in the following stages:

1. Platitudes. The members spend the first half-hour or more exchanging platitudes. They talk about things everyone can agree on without becoming hostile. Thus, they may talk about the weather, sports, current events; or they may try to explore the niceties of each other's names or origins. Staffs usually make themselves group members but they keep expecting the group to develop more initiative. One of them may ask whether the group thinks it can keep up this chit-chat for 30 hours.

It soon becomes evident that these platitudes are covering up hostilities--that these people get along so well in the world because they are, in effect, dishonest and do not wear their hearts on their sleeves. They pretend comfort with people who irritate them. They pretend interest in subjects which bore them.

There is certainly nothing pathological about forming relationships (and maintaining them) through platitudes. Most of the English language, most of the language of psychoanalysis, most of the language of business consists of platitudes.

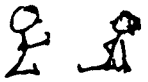
In the group's early hours the members get along by means of the platitudes they brought in from the outside world. If they stick with these platitudes they may each learn a lot of facts about themselves individually. The group will not change very much as a group, however. It will not develop a language of its own, it will not have unique experiences of its own.

2. Hostility. Usually the hostility begins to be expressed in jokes and then sarcasm. The members may have come to the group with prejudice against certain sexes, races, or types of individuals, or against authority in general, but they soon begin to express hostility appropriate to the particular persons present.

The risk one takes in expressing hostility is certainly greater than that he faces in maintaining the "nice image" that platitudes allow. For hostility toward another member or group may bring some painful retaliation. Nevertheless, such interaction is a well-known behavior pattern and is quite predictable to all members.

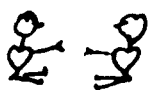
Hostility (and its more direct and personally expressive cousin, anger) brings out one's own individuality. It allows the angry person to feel much more strong upon his own feet and separate from other people than platitudes ever can allow--however elaborately intellectual they may be.

3. Sexuality. Sexual passes and gestures are often covered over with jokes or innuendoes, just as gestures of hostility may be. There are many hostile gestures, too, which are only later seen as covering up for sexual feelings.



The risk one takes in making a serious sexual invitation or gesture is far greater than the risk in a purely hostile gesture. The sexual advance, if rejected, is more painful than the rejection of a hostile gesture. Nevertheless, the person can pass it off by maintaining that he is merely a normal young person making a gesture at the opposite sex, and he expects frequent rejections. He may imply the opposite sex has no very important meaning anyway.

4. Tenderness. As the group progresses, a member will make some gesture of pure concern, love, or tenderness toward another member, or indeed, toward the group as a whole. A person who thus reaches forth his heart on his fingertips to another member, man or woman, is taking a great risk. Such offers are not frequent in our daily life. If at this point he is rejected he may be deeply wounded. Sometimes such a rejection is covered up by the member's attempt to turn it into a sexual gesture, or even a hostile gesture, saying in effect, "Oh, I really did not mean to offer you such a sickening thing as tenderness."



After a while, tenderness becomes an accepted thing throughout most of the group. Members feel at home with it as long as they are inside the group. If at this point the group breaks up, however, they cannot exercise this tenderness in the outside world--usually

5. Poetry. After tenderness has become an accepted fact in the group, one member will usually express the group's feelings in highly metaphorical or poetic terms. These terms go beyond the purely denotative verbal messages and they are freighted with several layers of meaning. Soon the other members would join into the poetry--each contributing his own personal artistic abilities and needs. Sometimes, however, the group put the "poet" on a pedestal and stuffed him with hubris.

To be fully grasped, these expressions have to be perceived in context, but here are some fragments:

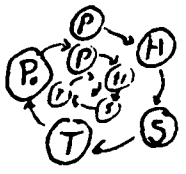
"What is that little jingling I hear?"

"That's the little rattle of tomorrow, outwaiting the cymbals of today."

In another instance the members walked out in the field and each picked a different flower. The iris and the buttercup, in the course of later conversation, came to mean exhibitionist strength and quiet manipulation. Then one member significantly placed a buttercup in a certain girl's lap and an iris in a boy's lap.

In a group of researchers one member said, "We carry our placentas around with us ready to leech onto whatever granting agency will allow us to continue our pregnancies." In the later group conversation, "pregnancy" and "placenta" had a special meaning.

The group itself accepts these metaphors as expression of feeling peculiar to the group itself and generated out of its own feelings, not necessarily related to what members shared before the group met, certainly not a repetition of old social principles or of poetic literature. These poetically-expressed developments of group emotion may themselves become agreed-upon principles which become a transcendent sort of platitude.



The group has now come full cycle but has spiraled inward upon itself, for these new platitudes belong only to the group--not to the outside world. The group may now dwell upon these platitudes and use them to extend common ground and to set itself at the beginning of a second cycle of these stages of emotional expression.

These, now poetic platitudes may cover up some new ways of expressing hostility or anger which have never before been reached by any of the members. The cycle then may proceed through this more complex hostility to a deeper form of sexual expression than was possible before. It may proceed onward to a correspondingly deeper tenderness and eventually to a deeper harmony of group poetic expression.

It is a mistake, however, to think that these discoveries can be directly useful or even directly explained with people in the outside world. Their usefulness is more in strengthening the individual. In this respect the development is similar to a religious development. But of course we must include in such "religious" development science itself as well as psychoanalysis, and much of the law.

Sometimes the group expresses these emotional stages out of sequence, or it may skip a stage altogether. It is seldom that a group in the course of 30 hours will go through more than two such 5-stage cycles.

These stages, it must be remembered, do not develop in group sessions which last only one or two hours, nor do they develop if the members are armored from each other by sitting around in chairs or in too large a room.

The staff expectation that some such cycle of emotional expressions may occur helps it to develop with the group. But the group and its staff should not consider these stages of expression as more than a framework upon which to build their own useful concepts within each unique marathon.

Does this mean we have finally relegated Freud's sexual drives to a transient third stage in a grand cycle of human growth? No, in spite of our ability to demonstrate this cycle in dozens of marathon groups, we shouldn't come to that conclusion. Rather, we should say, "A psychiatric theory is demonstrably true as long as it's in style." If a band of us dedicates itself to this cycle theory, it'll prove more useful than a Freudian libido theory which we are less enthusiastic about. But the Freudian theory will still do just as much for the traditional therapists who work with the symptomatic internal aspect of a single patient's life.

MODALITIES OF COMMUNICATION

When 15 or more people maintain intimate and unbroken group communication for 30 hours or more, a new kind of clarity is manifested among the communication modalities of voice, vision, and touch. Each modality has its own peculiar powers, its own peculiar defects, which do not show themselves in brief group sessions.

1. Voice communication is primarily a communication of the individual speaker to the group as a whole. He is usually speaking for the group--saying things the group can tolerate, can understand, and needs to hear. But even if speaking contrary to part or all of the group, all voice communication is in some measure the group speaking to itself.

The speaking member may try to communicate directly and privately to the listening member but as long as others can hear, he modifies his vocabulary and his tone of voice in accord with the kind of group that he is in. If he speaks with a vocabulary the group as a whole cannot understand, then this speech becomes a special gesture toward the group. If he speaks too quietly his words insult the group.

Normally, then, spoken words are never private you-me communication. They are, at best, me-group communication. And indeed, they are usually group-to-itself communication.

Since the group, at least in its early stages, has no language peculiarly its own, any verbal communication puts the group in a traditional language setting. It must use the words handed down to it by the English language over the centuries. Some of the words, of course, have modern meanings--witness the changed meaning of "Mickey Mouse" in recent years.

In a group, then, it is impossible for a pair of members to delineate verbally and accurately all their private communications and to analyze them outside of the group context--as if the group were not there. A group member once remarked, "Talking in a group is like talking on the radio--you are broadcasting. Even if others turn off their attention or go to sleep, still they might at any time choose to hear, and that possibility affects the conversation between the two of us."

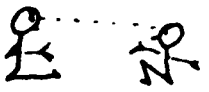
There is one exception to all this. If the two members whisper into each other's ears, then private you-me verbal communication can be held within the group setting.

If the two employ a soft breathy whisper rather than just a quiet vocalization, then the intimacy seems to increase. The intimacy is in part brought on, of course, by the proximity of lips to ears--to that intimate aura of personal territoriality. In addition, the whisper is a gesture toward the group and may insult or endear it.

Nevertheless, the whispered word content does not belong to the group. It is almost completely uninfluenced by the group. Mouth-to-ear whispering is an intimate you-me communication, similar to telephone conversation. For the telephone transmits a thin voice directly into our ears. In spite of some wire tapping, people feel it is very personal.

2. Eye to eye communication is an intimate you-me encounter. When two communicating members look directly into each other's eyes a third member, looking over a shoulder, can see only one member's eyes. The communicating member not only sees those eyes but he also knows what his own eyes are doing. If the third member swings aside to look at both pairs of eyes, he cannot see the same thing that the two communicating members see. Even a hand gesture has a special appearance to the member it's meant for. Visual communication, therefore, can be directed toward a single individual exclusively, intimately, and with high fidelity of meaning. Unlike a voice broadcast, it does not give the same sensation to all members of the group.

Misperceiving the group nature of speech, some people try to do individual therapy in a group setting. They treat at this individual, and then at that one. The therapist feels that he beams his own personal set of skills upon one individual at a time. Actually, his words broadcast to the group as a whole and not privately to this individual.



The group therapist cannot tailor his therapeutic influence specifically for this individual unless, perhaps, he carries on all his communication by whispering or by long gazes.

3. Tactile communication, we found, is always a communication of humanity to humanity. The member who touches another becomes a member of a species touching another member of a species. He is not primarily a distinct, well-delineated individual who is communicating well-delineated, high-fidelity personal messages to another individual.

For example, if a member meets a friend in the dark and in so much ambient noise that they cannot hear, then he may possibly identify the friend by finger-

ing the cast of his features, the warmth, resilience, oiliness, and tension of his surfaces. But after the identification, his recall of the entire discrete individual comes out of visual and verbal memory, not out of his store of touch images.

When five or six people form a circle and touch their many feet together in the center, then it is difficult for an individual to tell which foot is his own, much less which foot is John's or James'. The same applies to hands. When in some marathon groups a member is lifted up and "rocked" by eight or ten others he describes a sensation of floating on a sea of human hands. There are 20 human hands hefting him and he cannot tell one person from another. He only knows that he is very comfortably supported and swayed by four persons on each side and two at the head.

When a member is blindfolded and several other members hold his hands, his feet, or other parts of his body, and perhaps stroke him, he is consistently unable to distinguish one individual from another. He will misidentify the sex about half the time. Touch, then, supports and furthers a true you-me relationship only if the relationship was previously established in verbal and visual communication.

These principles of touch usually do not apply to men who have been blind over a long period of time. They develop more discriminating and more personal tactile communication--especially if they are also deaf.

* * * * *

When a group changes its primary modality of communication, then it changes its very definition of "person," of individuality, of message fidelity for emotions and ideas.

When most psychiatrists speak of "insight," for instance, they mean verbal insight. Now, there are two kinds of verbal insight--written verbiage and spoken verbiage. Written word insight is the most purely intellectual, the most critically analyzable, and the most timelessly permanent. Its meaning is narrow and certain. This is really the clarity traditional psychotherapy strives for--whether or not it's actually written down. Spoken word insight, on the other hand, is more personally and totally involving to the individual. It is more emotional. It is more subject to uncertainty of interpretation.

When marathon group staffs speak of an equivalent of individual insight, they may mean the visual recognition (in another person's visage) of the effects of one's own projected feelings. Or they may mean the tactile sense of bodily existence of another homo sapiens and the meaning of their solid animal contact--as against the verbal intellectual existence of an isolated individual.

Verbal communication seems to generate the most violence and other adversary gestures in the groups. Visual communication is the next most stimulating to adversary relations. Tactile communication seems actually the most resolving and quieting of individual differences. A leader can most easily galvanize a group into a particular cooperative action or a particular belief if all the members are holding hands.

In several marathons two members have argued hotly in an almost court-of-law adversary atmosphere. Most of the group members took one side or the other of this argument. The staff then induced all the members to weave themselves into a human rug on the floor. Some members formed the warp and others fit in as the woof. The staff encouraged the members to continue their argument while woven into the rug. All the members were surprised to find their argument became fragmented, halting, and without any force of contest or adversariness. As a human rug, with a great deal of their bodily surfaces in contact, they could best produce fantasies, dreams, poetry, and myths about themselves as a group or as ideal role-images. It was extremely hard for any member to be individually assertive of his own personal identity or of his contrast with other people.

Thus, to change the emphasis of communication from one sense modality to another changes the kind of emotional and intellectual work the group can do.

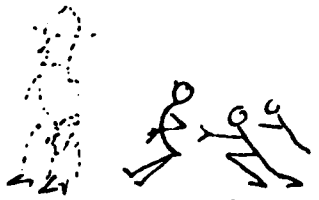
ROLES AND CHARACTER

In a marathon group, character seems most usefully defined as the habitual role that an individual manifests in his society. A role, in turn, is a certain set of behavior patterns which is needed by a group.

The stereotyped role of "villain" may be an ideal pattern of all the bad behavior that a group sees as necessarily existing in its world. In a particular fairy story or in a particular living group, the villain role carries certain bad behavior specific to that group. The community may need a greedy, avaricious man who likes to take advantage of poor widows and foreclose their mortgages. This role would allow all other roles in the community to become purified of avariciousness by projecting any such feelings into the villain role.

Now, the villain role is not a person; it is merely a field of emotional forces within the group. It is a focus of forces which calls for some person to fill that role.

A villainous character is a person who has gotten into the habit of filling only villainous roles in one group after another. Most persons, of course, are not such pure characters but they carry within them, admittedly, mixtures of many roles. In fact, they carry all the roles that their group normally needs. But a person usually emphasizes one role above all others.



In a group, then, a role is always in search of a character, and a group is always ready to see any person as a certain kind of character if he will fill one of the group's needed roles.

A strong and broad personality--not confined to a narrow character--may be developed by moving a person through each of the major roles of his culture. This movement is accomplished through sports, literature, and social activities, as well as through the patterning of family roles and responsibilities. A child is made to act both as a leader and a follower. He acts as a parent while he cares for a pet, a doll, a younger brother. He is made to feel a villain's emotions when he reads the story of Othello. He identifies himself sometimes with Iago and other times with the bad side of Othello. The childish jealousies

and envies that he may have in his everyday life are magnified, delineated, and concretized when he lives through in his imagination the characters he finds in Othello. The qualities in his own heart that his culture expects him to hate he thus defines and projects outside of himself and onto the characters of fiction, of sports, and of community life. He can reach his broadest character development if he does not project any of these feelings more than temporarily. A strong character can feel and live, at least in his imagination, all the major roles required in his group.

"Weak characters," "bad characters," or "sick characters" are appellations usually applied to people who make a career of a small set of social skills--a single narrow character. These people have only partly developed the breadth of their role potential. Equally incomplete in their character, however, are persons seen as purely angelic or characteristically generous, self-sacrificing, or perfectly honest. A contract between the character and his group allows the group to see him as maintaining only these nice attributes.

The villainous character, then, when sensitively educated, becomes less afraid of the good and the angelic within himself. He becomes able to practice good work as well as to tolerate his bad impulses. On the other hand, the good character so educated becomes less afraid of the bad impulses within him, and he becomes able to live as a fully rounded person, with all those human feelings but not behaving in a way which is destructive within his group--certainly not projecting his bad proclivities onto someone else.

THE DEVELOPMENT OF ROLES

In order for group members to characterize a scapegoat--set him in his role--each member must lose something from the fullness of his own character. For example, many groups will develop a beauty queen. This is usually one of the youngest and prettiest girls in a group of men and women. Typically, the men come to worship her. The women also worship her and say they wish they looked and acted like her. At the same time, the women are jealous of her and hope that she feels guilty for being the character that she is within this group. The beauty queen, then, is dehumanized. She is made into a sort of marble angel. She is not seen as Mary Brown--one of us--a girl who has many good and many bad attributes, some peculiarly and uniquely her own. On the contrary, she is seen as the kind of person the group needs her to be in order to fulfill its own ideals of a beauty queen.

The men worship her and try to gain her favor, not because of the unique person Mary Brown, but because the feelings of all the men are interlocked. If a man gains the favor of the beauty queen he gains status in the eyes of the other men who want that favor. He is seen as a great man himself and is envied by his friends. The member himself is not usually aware that this is his true feeling. Toward the beauty queen he feels inside himself a magnetic attraction which he thinks is peculiarly his own. He does not know the group set it there.

Each woman of the group, on the other hand, would also like to have the acclaim of the men. She would feel some guilt about this, of course. She would feel guilt for "loving" so many men at once. She would feel guilt for betraying the men that she is already committed to in her family or social life. The women at this point impute their own guilt into the beauty queen and expect her to feel guilty for being the beauty queen. They expect her to feel a great deal of guilt

for the "betrayal" of her own husband or boy friend back home. The beauty queen will often say that she is not her normal self. Sometimes she says, "All I can do is feel. I cannot think any more."

The task of the consultant or the leader in such a group is to make it easy for the women members to take back from the beauty queen their own self-confidence concerning their attractiveness, their own guilt about their feelings for men, their own tendency to seek excitement outside of their families. After this it is easier to have the men take back from the beauty queen their own ideals of what a perfect woman should be, and to see her as Mary Brown. At the same time, they should become able to express their own peculiar feelings of tenderness and hostility directly at each other as men and not by using the beauty queen as sort of a football to play a social love game with. When these imputations are taken back from the beauty queen then she as Mary Brown will be able to feel that she is truly herself, that she is a mixture of good and bad, and that she can think and feel clearly.

A CASE OF ROLE DEVELOPMENT

A certain marathon group, at about the fourth hour, had gone through a period of mixed platitudes and hostilities and had made some mild sexual comments. Members had just returned from lunch and seemed to be in a dependency state, expecting to be fed emotionally by the three consultants in the group. Since there had been some expressions of sexuality and tenderness, the consultants looked for an opportunity to set up a pairing situation, in order to get the group to develop a fuller group culture, to pass members through various roles, and to reason more intuitively.

Marie at this point said that she rather liked Dan. Her expression seemed to have in it a bit of tenderness as well as nonchalant friendliness. One consultant immediately got Dan to lean back on the consultant's knees. He then had Marie sit Buddha-like in front of Dan with another woman's back as a back-rest. Marie and Dan were told to look into each other's eyes deeply and to search for whatever they could find there. Then they closed their eyes and tried to recall what they had seen. After this, with eyes closed, they felt each other's hands carefully to see what characteristics or communications they could perceive. Then they whispered into each other's ears what they had discovered in each other.

Thus a strong pairing or coupling situation developed, with an audience sitting around it doing nothing except expecting great things to develop out of this pairing. Note that the modalities of communication used were mostly you-me communications and not me-group communications. The touch, coming after extensive visual exploration, tended perhaps to emphasize the animal species aspect of human relations.

After their whispering, the staff separated the pair to opposite sides of the room and asked the two to describe to each other in normal voice what they had experienced and what they were now experiencing from each other. (Note that this vocal communication was necessarily me-group communication since everyone could hear it.) Dan said that he had not seen anything in Marie's eyes except some gray streaks. He paid attention to her bangs, eyebrows, and other features surrounding her eyes but did not explore the depth of the eyes themselves.

Marie, with some disappointment from his attitude, described Dan's eyes as holding emotional depth for her. Then she began to stammer in her description. When the therapist pressed her, she said that she was having strongly personal emotions about Dan and yet she knew Dan's wife. The consultant passed over this and asked if there was anything else that disturbed her. She haltingly said, "There is a question of race..." Dan was black and Marie was white. Marie at this point began to cry. The consultant quickly went to her and held her hands down from her eyes so that the tears merely ran down her face while she looked the consultant in the eyes. This made clear you-me communication.

The group now became expectant that the pairing of Marie and the consultant would have important effects, but the group would only sit back and observe. Marie expressed concern about her own feelings for race and for the personal attributes of Dan as a human being. At this point, a second consultant remarked, "You do not suppose you are the only one here who has these feelings about race, do you?" The group members then began, one by one, to show a personal sympathy toward Marie, and to some extent, also toward Dan. Each member began to express his own emotions concerning race. One said, for example, that he had always thought of himself as a great liberal who had no particular perception of difference among races, but when he saw Marie's eyes aglow as she whispered into Dan's ear, with her cheek near his cheek, he was inflamed with anger and jealousy which he would not have felt if Dan had been a white man.

One by one the members in similar fashion took back their projection of their own racial prejudices onto Marie. Formerly they had assumed that Marie alone felt prejudiced. They now perceived their personal prejudices and their concern or guilt about those prejudices. Dan, of course, entered extensively into the discussion. Marie felt much relieved after the group took back from her all the prejudices except what naturally belonged to herself.

It became evident from this point on, however, that Marie was being set up as a beauty queen. She had been through the strong pairing experience and had appeared beautiful to the group in the midst of it. At the same time, some of the group guilt over sex was left within her. Hours later the women, and then the men, took back these dehumanizing feelings from her. Meanwhile Dan was seen as a fitting member with human characteristics peculiarly his own. All the men and women expressed considerable tenderness for him.

The consultants showed a lot of emotional involvement themselves in the group's feelings and in the pairing episodes that occurred. If the consultants had remained mechanical and had merely interpreted coolly what was happening, it is doubtful that the shift of attributes and roles within the membership could have occurred. The consultants by their very example would have given status to aloof detachment and ideal authoritative goodness. Note also that when the audience part of the membership began to experience its own feelings individually and to take back from the paired members the attributes imputed to them, then each individual in the group became more completely a character within himself. He was felt as a distinct person, necessary to the group, filling a role largely defined by himself. He was simply Joe or Jim and much valued by the group as that particular person. As an audience member, of course, he had merely been a part of an amorphous righteous mass.

SUMMARY OF MARATHON GROUP PRINCIPLES

1. The marathon group seeks primarily to improve the group as a whole--not any individual members. It is not considered therapeutic.

2. The group is large and impacted onto a small padded floor for 24 hours or more. Members sleep in the group itself while interaction proceeds around them.

3. The group usually contains a variety of trades and professions, ages, sexes, races, and social classes.

4. The group's intellectual verbiage is subordinate to gesture and the intuitive grasp of individual or group emotion.

5. Successive stages of emotional expression are usually:

   a. Platitudes.
   b. Hostility.
   c. Sexual expression.
   d. Tenderness.
   e. Poetry.

6. Different modalities of communication have different effects:

   a. Communication by spoken word is always me-group address.
   b. Communication by visual gesture or by eye-to-eye wordless language or by mouth-to-ear whispering is always me-you address.
   c. Communication by touch alone is a matter of human species addressing human species.

7. Groups set up necessary roles and tend to force those members with the most appropriate character structure to fill those roles. Each member stuffs the role's character with attributes of his own, which he then believes are peculiar to that character. When the members take back these attributes into their own self-images the character himself is freer to go on with his own peculiar way of behaving.

8. An individual's own life character and social sensitivity is broadened when he gets practice at identifying himself with several roles in turn.

HOW THE COMMUNITY CONSULTANT DEALS WITH THE STRUCTURE OF HIS SOCIAL SYSTEMS *

BY: Matthew D. Parrish

Modern physicists like Heisenberg and mathematicians like Goedel have proved that no system or institution can stand independent of all others. Thus there cannot be any system of geometry which is not also a part of a larger system of mathematics. It depends on that larger system for its existence and its reasonableness and meaning. Likewise every atom and every galaxy is an element in some larger system outside itself. Likewise a student is part of a school system and the school system is part of a larger community system which contains also jails, hospitals, families, industries, etc.

Now the community consultant can make use of these concepts as leverage in his work. Let's see how he can do it.

This may be fairly easy to see when the consultant is acting as a pure consultant to the total institution from the moment he enters the institution. But let's make it a little harder. Let's consider that the consultant enters the system by acting as a counselor to an individual.

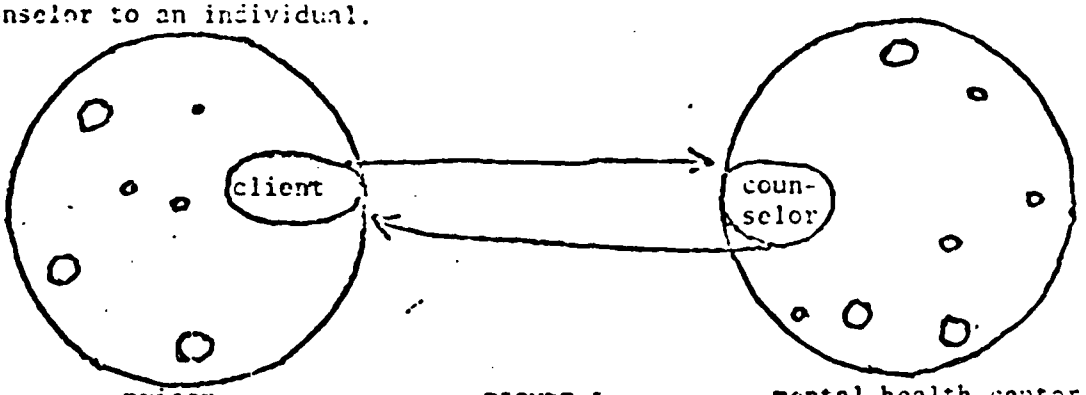


FIGURE I

Figure one shows the relation between the counselor and his client. In this case the counselor is a member of the mental health center and the client is a prisoner within a prison served by the mental health center. These two people remind me of signalmen on two ships which encounter in the middle of the ocean. The signalmen are flashing messages to each other. But are they talking merely to each other? Isn't one ship talking to the other? If we look further into the situation we find that one ship is a member of a Norwegian shipping line and the other is a member of the U.S. Coast Guard. Whatever these signalmen say has some meaning, however slight, to the U.S. Coast Guard and to the Norwegian shipping line. Now, of course, the mental health center is a part of the medical services of the community. The prison is also a member institution in the larger community and has close connections with courts, police and certain families.

The client-counselor relationship then is not merely a private you-me relationship. Rather it is an encounter between two open systems - between the counselor who is open to the mental health system and the prisoner who is open to the prison system.

The signalman on the ship did not receive his message because his name was Jim Jones and he hates coffee, smokes too much, is 25 years old and has two children. No, he receives that message because he is playing a certain role on that ship. The prisoner sees the counselor because the prisoner is playing a certain role within the prison and the prison as a whole wants the counselor especially to see this prisoner and

* LECTURE DELIVERED At Army Social Work Conference - Fitzsimons Gen. Hosp. 1969

perhaps not any other prisoner today. The counselor on the other hand plays a selective role within the mental health center. He is seeing prisoners today some other counselor is not.

The counselor does not counsel the client because he happened to pass him on the street. Rather he counsels this client as a member of an institution which is in turn a part of the larger institution, the community, to which the counselor also belongs.

The client is a communication:

The client's symptom (e.g. backache) is a communication. It is analogous to a written message in a letter. The client as a person is the letter paper.

This communication is always from an individual to an individual - from client to counselor. It is also always from a group to a group - from the prison to the medical profession.

If the counselor and the prisoner conceive of themselves as having only a private relation with each other, they are missing the essence of the work to be done. To understand the effect of the client's larger system on the client and his peers the counselor must ask himself four questions:

1. Why does the client present this particular symptom? He may have other problems he could have developed.

2. Why does he come out now from the body of prisoners? Why did he not attract attention last month or tomorrow?

3. Why does this prisoner come to medical attention and not some other prisoner who may be suffering even more?

4. Why is this prison and not some other institution in the community producing this symptom? Why doesn't the prison produce even more symptoms? It should be remembered that this prison may also be producing escapees, fights or enthusiastic work and not merely medical complaints.

These questions should prevent the counselor, the consultant or the doctor from being so misguided that he thinks a member of a prison, a school or a family comes seeking great benefits from the mental health professional's own peculiar personality. On the contrary the community member won't seek him at all if the profession isn't playing a significant role in the larger society which includes the prison or the family.

Staff role in the community:

It is doubtful that we can much longer speak of a counselor or mental health consultant as having a job. A job is a set of procedures which the worker performs and skills which he offers for sale. Qualifications for a job are a union card, a diploma, a license. A bricklayer does his work much the same on this house as on that one. A new construction contract does not change his attitudes, his goals, his

procedures. The counselor, however, in playing a role within a community must involve himself so much and so long in that community that he becomes a part of that community's planning and thinking mind. His office assumes a particular personality and it becomes dovetailed into the personalities of other community roles such as those in education, police, religion. He is effective then not only through his skill in conversing with a patient, but through his being involved professionally in the interlocking roles of the community leadership. It takes more time to know a community and develop a role within it than it takes to develop a client relationship and to know the client. For this reason some mental health workers say they need long tours with one community. On the other hand, community roles can often develop faster and to become more useful in moving the community ahead if new professionals come into those roles from time to time. An individual transfer affords that bit of role discontinuity that allows the community to make a certain needed adjustment of the role.

John Smith, for instance, may have spent three years developing his role of chief social worker in the mental health center, but he has far better relations with the lawyers than with the ministers in the community. Personally he is not so interested in ministers. Ministers accordingly have less participation in social work planning and thinking in this community. Now when Joe Brown replaces John Smith all the subordinates in the social work office give him the impression that ministers are important (they have been wanting to do this all along, but John Smith won't listen). When Joe meets the community leaders, the ministers impress him just as strongly as the lawyers. The role of social work has then shifted in this community.

Unless the consultant keeps his role in mind and his relation to the rest of the community, a client may play the role of "patient" so skillfully that the consultant is deluded into believing he is being consulted solely because of his own professional skills. This delusion may block him from involving himself with the larger system which is transmitting this patient.

Case example: How wide a system should we examine?

A prisoner breaks into the prison dispensary and swallows a lot of pills, making himself sick. Now, considering the physiology of this prisoner today, the doctors may wash out his stomach and seek to determine what sort of drugs he took so they can give proper treatment. They are occupying themselves with the system of the body and its physiology. Now, an individually oriented mental health worker might take a history which shows the prisoner was reared by harsh, demanding foster parents and therefore grew to hate all authority. Because of this he dropped out of school in the tenth grade. He took up drug abuse because he sought a more pleasant inner world. The police caught him because he was so addicted that he had to have a fix even though the police were nearby. The same inner urgency for drugs led him to break into the dispensary. A history like this can clarify the causes and dynamics underlying the patient's behavior. In the same way the physiological examination on the patient's body clarified the effect of the drugs upon him. Both kinds of examination are very satisfying to the particular kind of examiner.

If the mental health worker now looks further into the patient's membership in the groups and systems of his life, he may find that he dropped out of school when teachers were disturbed by large classes and unreasonable curriculum. They developed attitudes which unintentionally urged students to rebel for them. This patient was merely one of the protestors within the school system. After his drop-out he found himself stereotyped as a prominent and popular protester. The group of heroin users his own age then needed him to participate in the habit. Later the group needed him to get caught and to engage in a battle of giants--the police representing traditional society and the patient representing the protestors. In prison he found the other prisoners also needed to watch a battle of giants. Furthermore the custodial personnel had been getting a lot of criticism for the way they handled their work, but the medics in the prison never got any criticism. The guards neglectfully made it easier for the dispensary to be broken into.

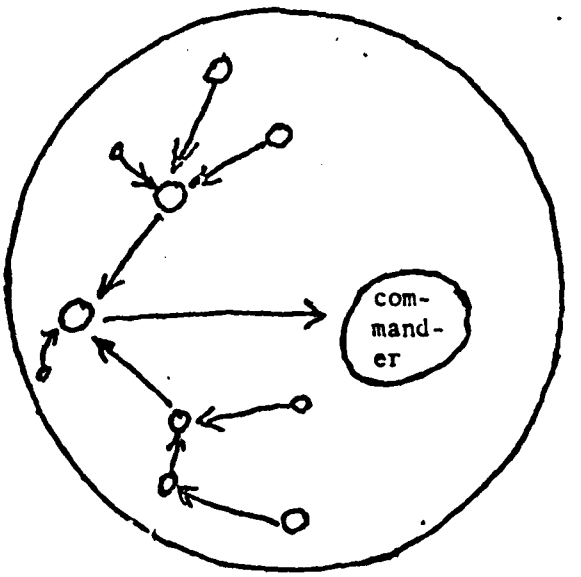
The mental health consultant might now concern himself with the relations between guards and prisoners, guards and administration. For this system is using the patient and his gestures as a communication to the world outside-saying: "There is something amiss in this prison."

Case example: The transmission of emotion from system to system:

Trainees in Company A were full of anxiety from trying to keep up with the stern demands of the officers. Protest was unavailing. Trainees began to look at each other and say, "I wonder who's going to crack under this strain?" Private Jones, a bit more sensitive than the rest, began to show more intense anxiety. The other trainees neglected their own anxiety to attend to him. This attention and concern transferred most of the group's anxiety onto Jones. He paced the floor. Finally he went to the company commander and said, "I'm on a hunger strike!" At this point his anxiety left him. He sat back to watch what his now anxious commander would do about him. The commander called the chief of the post hospital saying, "I can't stand this man in my company. I'm sending him to the hospital." The commander then turned calmly to his desk work.

The now anxious hospital chief quickly called the post psychiatrist saying, "This man is on a hunger strike. Put him on the psychiatric ward." The psychiatrist was chagrined that he had failed to consult enough with the companies so that they would contain and reintegrate such cases in their own units. Nevertheless he returned the anxiety to the patient saying, "You're an interesting case to write up. We're going to take pictures of you every day as you get skinnier. We'll also get some daily lab tests to see if we can predict autopsy findings." Private Jones thought, "My gosh, he's going to let me die!" He began to pace the floor again. Suddenly, however, a great idea came to him which relieved all his burden of anxiety. He called the local TV station and said, "I don't like the Army, and I'm on a hunger strike. Will you send a reporter to interview me?" Anxiety shifted back to the commander and the hospital chief until the company had group sessions which included the patient. Each member took back his share of the anxiety, and as a group the staff and trainees clarified their emotional communication.

Anxiety or other emotion can thus be transmitted from one group system or personal system to another in much the same way that a football is passed to another team or another player thus making that other system crucially important for a while.



Company A

FIGURE II

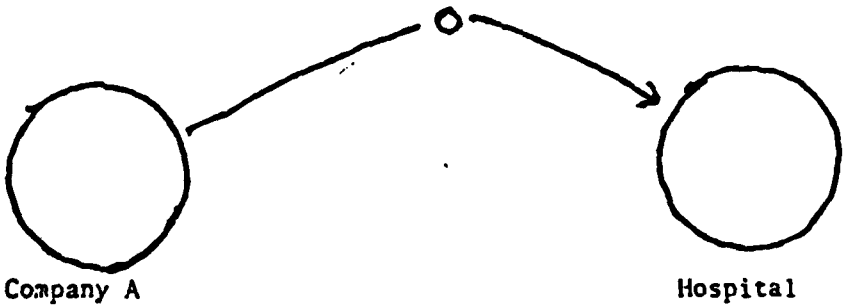


FIGURE III

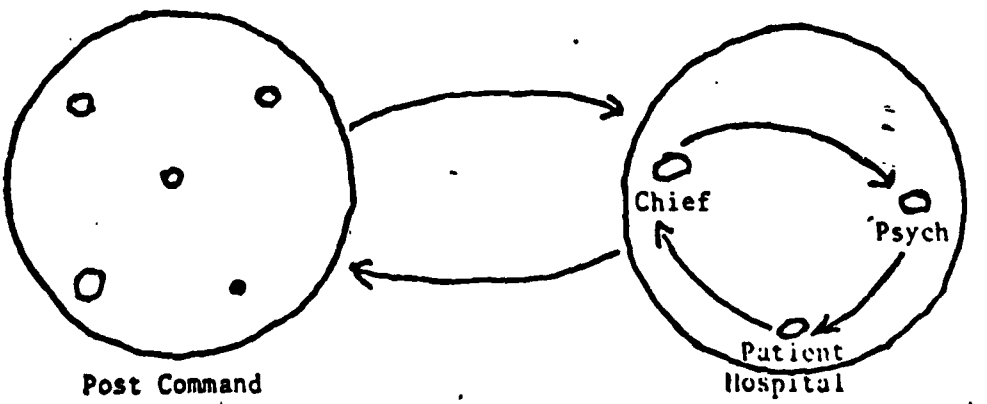


FIGURE IV

Figure two shows how group anxiety (represented by arrows) is condensed upon a group member who then passes it on to a manager within that system. Figure three shows how one group system delegates a member to carry the anxiety over to another system. Figure four shows this anxiety reverberating around in the second system and some of it bursting out.

Alternative evaluations and alternative case managements.

Most human relations problems can be worked up in terms of more than one client system or more than one level of system size. Attention may be concentrated on one or two of several possible messages being transmitted in the systems. All the alternatives may be equally true, consistent and convincing. A particular mental health worker may most comfortably view every problem as belonging to only one species of system. For instance he may see every problem as arising from within an individual psyche with its dramatic history and dynamics. He may on the other hand view every problem mathematically as a group personnel problem. Or he may view it as a manifestation of shifting styles of social communication with individuals being scapegoated to transmit feelings and information. He may view it as a matter of cultural pressures, instincts, hormone levels or drug usage upon groups or individuals. He may view it in many other ways, but it is most important to employ a point of view and a procedure of consultation which can do the most to help this particular problem.

Checklist regarding the immediate client system.

1. Who are the client systems?

   The client is always one or more groups (family, company, school, prison, team...) and often it is also an individual.

2. What difficulties are the systems having?

   The members are usually undergoing some threat to their image of themselves as worthy of high esteem from other systems. The company says in effect, "This company is faultless. This individual member, however, is having problems." Actually he is carrying the company's message. Or perhaps the group says, "The basic trouble is that we are poorly supported by outside systems which give us too little money and personnel or even try to trick us." The individual himself says, "There's nothing wrong with my thinking. It's just that I can't stand my outfit."

3. What are the alternative remedies?

   a. We can concentrate on some individual as the indicated client and help him to find a different role in the group or to get out of the group altogether.

   b. We can pass anxiety on to some other person

   c. We can get a group to help itself and its own members. Perhaps we can even change relationships among roles or change members from one role to another.

   d. We can get other groups, other systems to help this group.

4. What is the preferred alternative?

   Generally it is best to work with the personal or group systems which will give the longest future stability of function and the fewest symptoms. But it must be a project we can perform. We can't work out an alternative which involves a system we don't have the skill or power to affect. On the other hand our benefit will be short-lived if we deal only with a symptom or an individual. This usually means we have to develop better communication with larger systems, with staff officers, school boards, parents, churches and other institutions. In every ounce of an individual's cure there should automatically be a pound of prevention afforded to at least one of his social systems.

5. How do you know when you are successful?

   If your goal was only to relieve an individual's anxiety, you may be successful soon after he swallows his tranquilizer. Your success with the company or business may have to be measured in improved performance, staff efficiency, and decreased delinquency, accidents or sickness. The personal feedback that you get from good operational research measurements brings great technical improvement to yourself, your staff and your entire profession.

Checklist regarding the overall function of consultation.

1. What is the effect on the client system? Does the chosen method of management lead to improvement of individual, of group? Does the client system, make more money, commit fewer crimes, feel happier? Does it become dependent on the consultation unit so that you have to go back again and again even for the same type of problem?

2. What is the political effect within the total community? Will a certain type of management alienate the police, lose community support, retard educational progress or increase illness in others?

3. What sorts of management or consultation will afford the best measurements and the best feedback to us in our operational research?

4. What gives the most satisfaction and joy for the mental health unit and the consultant himself? Does the chosen method allow the consultant to live through a dramatic story, to increase his prestige or power contacts, to work with beautiful people, to gain an exemplary case for teaching? Many workers don't consciously consider this fourth factor and are therefore influenced by it all the more. A worker should be prepared to undertake a personally more painful procedure if the payoff is greater to the client, the community and the profession. Nevertheless, all other things being equal, the fun of the work is a very important consideration. If it is completely neglected, the consultant and his unit may deteriorate.

Summary. To be an effective human relations consultant...

1. Read any symptom as a communication not only from the individual bearing it but from his member group to some other group.

2. Explore the problem as an element in various levels of organization in the client systems, e.g.: organ, person, family, enterprise, institution, community...

3. Work upon those levels which produce the most useful and self-sustaining results.

4. Work yourself out of the project. Don't get a client system permanently dependent upon you as a worker. You fill a community role, not a job - a role that shifts as times change.

5. Participate in the measuring of your work results, their follow-up and their reporting back to you and your colleagues. You are always teaching and always learning...with your colleagues and with your profession.

6. Help your clients to control the transfer of symptoms and emotions from one system to another. Get members to share responsibility for all emotional problems in their member group.

7. Enjoy your work.

#48

THE INCREASING PSYCHIATRIC CASELOAD vs DECREASING STAFF[1]

by Col. M. D. Parrish

Even a psychiatric practice serving the total needs of a community--not just selecting cases for intervention according to the psychiatrist's personal desires and interests--may feel it needs to increase its staff every year. Psychiatrists find their caseload increasing beyond the capacity of present methods of case management; more trained defense attorneys request more sanity boards, more unconventional conscientious objectors appear, decrease in combat is accompanied by more delinquency, drug abuse increases... The first thought of the psychiatrist is to increase the number of psychiatrists. "With twice the staff we can do twice the work."

But medical progress has not been made by increasing the number of doctors; there are no more doctors per capita today than there were in 1900. But the number of patients and the severity of problems handled has much increased. We are doing more and better medicine with fewer doctors. Psychiatry faces now an even higher rise in problems. How can we handle them with fewer psychiatrists?

But how are we presently doing more with fewer psychiatrists?

(1) The most obvious way is by better employment of ancillary personnel. We are working more closely with nurses, psychologists, social workers, occupational therapists and technicians who handle patients just as sick as those most psychiatrists handle. But these ancillae have not been mere substitutes. They have improved the care more than a corresponding increase in psychiatrists would have. Social workers, for example, see patients and their supervisors where they live and work. Some occupational therapists are even more likely to see them on the job site. Nurses visit homes. Psychiatrists are only lately learning to touch patients with the care and tenderness nurses do and still promote therapy rather than disrupt it. Psychologists help design new treatment and follow-up methods in families, units, communities. They tailor micro-economic systems or therapeutic milieu to fit the immediate community needs. The enlisted specialists get closer to the social ramifications of problems. With them, patients put aside Sunday manners, supervisors show a truer side of self.

(2) The mental health personnel deal by consultation methods with those commanders and noncommissioned officers who are responsible for the patient's work and his living conditions. These consultants participate in command's planning for the patient's environment. Consultants sometimes influence patient welfare the most when they don't even mention a patient.

(3) The mental health personnel confer and plan with the patient's peers who often live with him 24 hours a day. Peers are not officially responsible for the patient, but in a humanitarian way they are deeply responsible for each other--the patient for them and they for the patient. Frequently the real problem is not the patient himself. He is merely a messenger (who perhaps cut his wrist) saying there's something intolerable within the unit. A unit group consultation (UGC) often straightens out both the patient's problem and the unit's.

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[1] Newsletter of the U.S. Army Med. Dept., Vol. 1 No. 3, Oct., 1970, pp. 44-46.

In a UGC the patient and some of his peers meet with a unit officer and NCO in the presence of a mental health consultant. Some have imagined a UGC is a sort of group coercion of the patient. On the contrary, the medic in the conference acts as a restraint on the command, and the command acts as an enlightening restraint on the medic. In such a dialogue the actions most beneficial for patient and unit are the most likely to be executed. Without such conferences the doctor may autocratically do what's "best" for the patient.

In drug, alcohol and some delinquent problems, peers especially help when they, themselves, have been addicted to that problem and have gotten over it. They bring the most effective intervention to bear on the young experimenters with these problems. Sometimes, too, a buddy is made a special companion for an anxious or disturbed patient under outpatient observation. The mental health personnel see both buddy and patient in the follow-up interviews. They obtain stronger leverage on behavior.

(4) The Mental Hygiene Consultation (MHCD) often handles the situation as a systems problem. The system of interlocking influences of various roles and personalities within unit, families or cliques may produce a patient as a manifestation of maladjustment within that system. This means the consultant (usually together with the commander) must understand the significant group and the patient's place within that group. He must question how much the patient can change autonomously and how much by coordination within the group. A good consultant gets the patient to participate in the planning of his own change and the environmental changes affecting him. Improperly used, the system approach can become a cool manipulation of objects with little feeling for the persons. More properly the systems approach can reveal the best roles to alter and the personal assets to strengthen in order to help men become more creative and more usefully autonomous.

Sometimes it's best to try to change fads and styles of behavior rather than to concentrate on any individual's behavior. Some commanders and their consultants, for instance, handle drug abuse as a style of social behavior, not as a problem unique to this or that individual as if the individual were not himself caught up in the grant style. They may approach this problem by a change in the method of carrying out a mission, by using "advertising" methods or by setting up an imitable hero.

With all these methods in mind, a consultant from Department of the Army who looks at your psychiatric operations will probably ask: (1) How do the consultants to local units communicate their experiences to the rest of the psychiatric staff as a form of training? (2) How does the psychiatric staff keep charts on work done with units as well as the simultaneous work done with patients? (3) What proportion of work is really consultation in the field and how much is office interviewing? (4) Does virtually every member of the staff have responsibility to consult with some units? The Chief especially would be expected to have such responsibility--though usually for higher echelons--because junior staff will imitate the Chief.

Even with full knowledge of these methods psychiatrists will sometimes ask: "How can I be a consultant to command until I have two more psychiatrists to help me with this big load of 1,000 patients a month? All these sanity boards, administrative evaluations, neurotic dependents and troops, alcoholics, drug

abusers, prisoners, people who'd rather not go to Vietnam--they all take up my time. Why should I go outside my office to see anyone? It wastes time. I see fewer patients that way."

Well, suppose you as a psychiatrist go to Company A's orderly room to see the next referred member of that company. You talk to the commander about the history of the case within the unit and discuss what appears to be the best course of action. About half the time you will find that the commander has not talked to the member about the very problem the commander is anxious about. Your consultation will take more time than a mere office interview. But the unit's feeling of responsibility will be broadened. As long as you stay in good contact with that unit, it will send you only half as many referrals.

If a member of the mental health staff sits in the battalion headquarters on the periodic meetings for company commanders or first sergeants, he'll eventually get these managers of men to influencing each other for better leadership, better morale, less need for the units to develop patients. For psychiatric patients do not just occur spontaneously at a fixed rate. Some companies and some posts produce several times the rate of both inpatients and outpatients as others do. In general the fewest problems come from posts where commanders, troops, staff officers and mental health personnel coordinate to guide behavior along courses most satisfying to both individual and unit.

Further good innovations are on the way. You can help by writing up your observations for publication, and also by sending your suggestions in to: The Surgeon General, ATTN: MEDPSCN, Department of the Army, Washington, D. C. 20314.

#49

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ARMY MENTAL HEALTH ACTIVITIES IN VIETNAM: 1965–1970*

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This paper provides an overview of U.S. Army mental health activities in the Vietnam combat zone from the escalation of mid-1965 to the significant de-escalation of mid-1970. Both authors are currently (May 1970) serving in the Office of The Surgeon General of the Army in Washington, D.C., where Colonel Parrish is Chief, Psychiatry and Neurology Consultant Branch, and Major Colbach is Assistant Psychiatry Consultant. Colonel Parrish was the Consultant in Psychiatry in Vietnam for 12 months during 1967 and 1968; Major Colbach served in Vietnam from October 1968 to October 1969, and for most of the time he was Chief of Psychiatry at the 67th Evacuation Hospital in Qui Nhon.

Prior to mid-1965, the only mental health facilities for the small U.S. force in Vietnam were at the Naval Hospital in Saigon, where a Navy psychiatrist was based. With the escalation this rapidly changed, and this is the first conflict in which U.S. Armed Forces have been involved in which trained mental health personnel have gone forward with the troops from the beginning.

Overall, for every 50,000 Army troops, there have consistently been

* This material has been reviewed by the Office of The Surgeon General, Department of the Army, and there is no objection to its publication. This review does not imply any endorsement of the opinions advanced or any recommendation of such products as may be named.

The authors wish to thank Mr. George Allen of the Medical Statistics Agency, Office of The Surgeon General, Department of the Army, Washington, D.C., for his help in compiling the statistics.

on the average, three psychiatrists, two psychiatric social workers, and twelve enlisted specialists. These last are usually college educated young men, with an aptitude for the social sciences, who have been trained to assist the officers in consultation, evaluation and treatment.

From the early stages of the escalation, there have also been present in the combat theater senior military consultants in psychiatry and social work. There have usually been two Ph.D. clinical psychologists in the country.

The general medical officer, who works in the field at the battalion or dispensary level, has proven to be quite sophisticated in mental health principles. He has often been the real first line of defense against psychiatric casualties.

Almost all of the mental health personnel who are not career soldiers have been given a basic military orientation course at the Medical Field Service School at Ft. Sam Houston, Texas, before departing for Vietnam. Here such terms as "field consultation" and "command consultation" are bywords to indicate the importance placed on treating a soldier in his unit with the help of the unit caretakers, such as the soldier's commanding officer, his sergeant, or even his buddies.

In Vietnam, the emphasis has been on the regional deployment of mental health personnel. About one-half of the in-country personnel have been deployed in echelons farther forward than hospitals. There have been three levels of mental health services in the combat zone: (1) division mental health services; (2) large hospital mental health services; (3) neuropsychiatric special treatment team services (called KO Team as a code symbol).

The divisions have been the main Army fighting forces in Vietnam. Each division, of between 15,000 and 20,000 men, has had one psychiatrist, one psychiatric social worker, and from six to ten enlisted technicians. The technicians have been stationed with the smaller units, while the division psychiatrist and social worker have called the main base camp their home. There has been considerable traveling back and forth, however, as a division may be quite scattered. A division psychiatrist has usually had his own jeep, and helicopter transportation has been readily available.

At the division level most patients have been seen first by the enlisted technicians, right where the problem has arisen, and medication given, if needed, by the unit general medical officer. Often others in the patient's

unit have been called upon to help in getting him back to good functioning. This may take the form of the technician having a private conference with the sergeant, or of an impromptu group meeting with the patient and some of his buddies.

Cases which the technician thinks to be beyond his level of competence have been handled in different ways. The technician might decide to return the soldier to limited duty and await the regular visit of the division psychiatrist or social worker in a day or two. At that time the technician might call upon the patient's superior to present the case to the mental health officer, to assure the superior's full involvement.

Real emergency cases have usually been evacuated to the small division clearing hospital, where brief hospitalization has been available on a general medical ward. There have been no locked facilities at this level, or in all of Vietnam, although restraints have been used if needed.

If a patient has not responded after this brief hospitalization, he has usually been evacuated in the country to one of the two neuropsychiatric special treatment teams. For those people returned to duty, follow-up has been excellent because of the scattering of mental health personnel throughout the division.

If the individual presented himself mainly as a personality disorder, and rehabilitation potential seemed poor, an alternative would be to recommend administrative separation as unsuitable or unfit, under the provisions of Army Regulation 635-212.

Because of their many contacts throughout the division, mental health personnel at this level are quite adept at preventing problems before they arise. They generally have the power to manipulate the environment in many different ways, and probably their main contribution has been in the area of preventive psychiatry.

The second level of Army mental health services in Vietnam has consisted of the large, 200–400 bed hospitals scattered throughout the country to serve the large body of support troops. At one time or other, mental health teams have been stationed at the 3rd Field Hospital in Saigon, at the 6th Convalescent Center in Cam Ranh Bay, at the 67th Evacuation Hospital in Qui Nhon, at the 71st Evacuation Hospital in Pleiku, at the 91st Evacuation Hospital in Chu Lai, and at the 95th Evacuation Hospital in Da Nang.

These large hospital teams have generally consisted of a psychiatrist, a social worker and a few technicians. These hospitals have usually been

able to hold patients about ten days on an unlocked general medical ward. Patients not responding at this level have been evacuated in the country to one of the two specialty teams. Usually only the two neuropsychiatric specialty teams have had the power to evacuate patients out of Vietnam to Japan. This clearing of all out-of-country evacuations from division and large hospital levels has tended to negate the effects of local political pressures to get rid of a troublesome person and to negate the effects of the local psychiatrist's own anxieties about a particular case.

Large hospital psychiatry in Vietnam has tended to be more traditional than division psychiatry in the sense that it has been hospital and office oriented rather than field oriented. The large number of small support units have had much less group identity than the combat divisions, and mental health personnel have responded to this in part by staying in their offices. Although there have been exceptions, preventive psychiatry has been at a minimum at this level.

The third level of Army mental health services in Vietnam has consisted of the two neuropsychiatric specialty teams, called KO Teams. These two teams have had the primary responsibility of serving as backup for the first two levels of care. One team has been assigned to the northern half of Vietnam and the other to the southern half.

The concept of these teams has been that of mobile units that can move where needed. In reality, however, they have been relatively stable, although sections of these teams have gone to places of need from time to time. The 935th Medical Detachment has long been attached to the 93rd Evacuation Hospital at Long Binh. From early in the military buildup until just recently, the 98th Medical Detachment has been attached to the 8th Field Hospital at Nha Trang. Recently, in response to troop changes, the 98th has moved to Da Nang.

Each of these teams has had from three to seven psychiatrists, two to four social workers, a clinical psychologist, a neurologist, one or two psychiatric nurses, and as many as twenty-five enlisted men. Although physically attached to large hospitals, they are technically separate, and could function on their own. Each has had a psychiatric inpatient ward with up to thirty beds, and these wards have been capable of holding patients for as long as thirty days. Again, they have been unlocked and have had no seclusion rooms.

Both of the specialty teams have had electroencephalograph machines. Neither has had facilities for electroshock treatment. The KO Teams

have also provided a variety of outpatient services, including such things as Alcoholics Anonymous chapters and treatment groups for drug abusers.

Communication between all three levels of treatment has been very good. The senior consultants and individual mental health personnel have traveled a great deal. Also there have been "Free World Psychiatric Conferences" at one of the KO Team's locations, with everyone invited, as often as four times yearly.

Mental Health Problems in Vietnam

It is important to realize that actual prolonged contact with the enemy has been the exception in Vietnam. Large battles have been rare in comparison to Korea and World War II. Therefore, combat itself has generated only a small number of psychiatric casualties. The diagnoses of combat fatigue or combat exhaustion have been limited to those individuals showing such specific symptoms as tremulousness, insomnia, nightmares, severe somatic complaints, and startle reactions which are directly related to a period of combat. Such cases have been in the minority.

For the most part, the same range of descriptive diagnoses has been demonstrated in Vietnam as might be expected for a similar group of young men in the United States. The impact of such precipitating factors as boredom, loneliness and interpersonal conflicts has been somewhat intensified due to the stresses of living a regimented group life in a hot foreign land where there has been a constant threat of bodily harm. When leadership has been good, however, these stresses have been minimized. Most often specific problems have arisen as a result of poor leadership with a subsequent decline in morale.

Marihuana has been widely available in Vietnam, where it grows in abundance. Significant numbers of soldiers have used it, although exact statistics are difficult to determine. A transient psychosis associated with marihuana use, and marked by paranoid and organic features, has been a common occurrence. Overall, however, marihuana use has not seriously affected the military mission.

There has also been abuse of French barbiturate and amphetamine preparations obtained from the local populace, although the magnitude of this problem has not approached that of marihuana abuse. Hard narcotics have been used rarely.

The abuse of drugs has been considered a prerogative of the young

soldiers, who have generally avoided alcohol. The older career soldiers have avoided drugs, but some of them have turned to alcohol to handle the isolation and boredom.

The racial problem in the United States has extended to Vietnam. Black power feelings have become quite strong at times, and such things as Afro haircuts, extreme clannishness, and black power signs have become commonplace. There have been some outbreaks of black-white violence, and everyone has become increasingly edgy about the situation. The Army has been taking many steps to ferret out causes of racial conflict so that they can be corrected. The racial issue has become such a sensitive one that any incident involving black and white soldiers has been considered to be of racial origins. The whole situation has had an adverse effect upon morale.

Psychiatric Casualty Statistics

A soldier is considered to be a psychiatric casualty when he misses 24 hours or more of duty due to psychiatric reasons. For practical purposes, this is equivalent to hospitalization, since confinement to quarters is a seldom used form of treatment for psychiatric problems. Statistics in The Surgeon General's Office show that the rate in Vietnam for such conditions as compared to that in the United States, expressed in casualties per 1,000 troop strength per year, has been as follows:

	Vietnam	United States
1965:	10.8 per 1,000 troops per year	9.1 per 1,000 troops per year
1966:	11.5 per 1,000 troops per year	10.7 per 1,000 troops per year
1967:	9.8 per 1,000 troops per year	9.5 per 1,000 troops per year
1968:	12.7 per 1,000 troops per year	9.9 per 1,000 troops per year
1969:	15.0 per 1,000 troops per year	10.4 per 1,000 troops per year
1970 (through June)	24.1 per 1,000 troops per year	12.0 per 1,000 troops per year

This compares with the rate during the Korean War (July 1950 to December 1952) of 37 per 1,000 troops per year. The rates in World War II in combat areas ranged from a high of 101 per 1,000 troops per year (First U.S. Army, Europe) to a low of 28 per 1,000 troops per year (Ninth U.S. Army, Europe). Comparable rates for World War I are not obtainable.

Most significant in these statistics are the low psychiatric casualty and evacuation rates in Vietnam as compared to those in previous conflicts, and the recent marked rise in these rates. The rates began to rise in late 1969, and in June, 1970, reached 37.6 per 1,000 per year, a monthly Vietnam War peak.

Admission diagnoses of psychiatric casualties in Vietnam have been recorded in only five broad categories, so they give limited information. The following approximate percentages have remained fairly uniform from mid-1965 to the present, despite the increasing rate: psychosis, 20 percent; personality disorder, 30 percent; psychoneurosis, 15 percent; combat exhaustion, 7 percent; other, 28 percent.

Despite the increased casualty rate in recent months, it is obvious that the American soldier in Vietnam has generally been psychologically healthier than his counterpart in previous wars. Various reasons are given to explain this.

The nature of the conflict, with sporadic rather than prolonged fighting, has certainly been a factor. The United States has had clear air and naval superiority, and supplies have been plentiful. For a combat zone, communications have been excellent. The American soldier has a higher educational level, has been better trained and better led than ever before. The tour in the combat zone has been limited to 12 months, except for volunteers who ask to extend, and this has provided a concrete goal for which to aim. The rotation has had its adverse effects, though, in that the constant personnel turnover has hurt group ties. The "R&R" (rest and recuperation) trip to any one of a number of Asian cities has been a mid-tour break much looked forward to by everyone. And, of course, the thorough network of mental health services which has been described, with the emphasis on keeping the individual functioning within his group, has most probably been a factor also.

How well this emphasis on group ties has worked has been best demonstrated by many of the psychiatrists themselves. Upon arriving in Vietnam, the average psychiatrist has wanted to be assigned to one of the large hospitals or psychiatric specialty teams, where life has generally been more comfortable and more safe than at the division level. After six months with a division, however, only rarely has a psychiatrist been willing to leave "his men" when given the opportunity to move to one of the originally sought "better" echelons.

Morale has been generally good in Vietnam. The average soldier has

been concerned most with the problems of living in a large group, far from home, in a hot and muddy foreign land. He has not seemed overly concerned with the justification for the war. Upon arriving home, however, that same soldier, given an appreciative audience, will speak long into the night on the political aspects of the Vietnam involvement.

The increased psychiatric casualty rate in the past ten months is a cause for real concern. The reasons for it are not clear. The level of fighting has certainly diminished, and it has long been an observation of military psychiatrists that troops in a combat zone often have more interpersonal problems during lulls in the fighting. It is hard to judge what effect the apparent intent to disengage from Vietnam has had on troop morale. Further study is indicated before any conclusions can be drawn about what appears to be a new psychiatric phase in Vietnam.

Specific Treatment Techniques

Much has been said about preventive mental health, and certainly this has been the main emphasis in Vietnam. Some mental health personnel have been quite effective in going into a unit, finding areas of interpersonal friction and correcting them before members of the unit become psychiatric casualties. In the area of racial problems, however, this technique has been underused.

In the area of drug and alcohol abuse there have been some attempts at group reeducation, but these have not been pronounced. Probably this has been so because these problems have not greatly interfered with the mission.

This is the first war in which the new phenothiazine medications have been available, and they have been widely used in all kinds of conditions. They have been safely used to control excessive anxieties in combat infantrymen without any apparent interference in duty performance.

One specific technique called "sleep therapy" has been popular in the management of all types of acute upsets. The usual method has been to give an agitated or psychotic patient a starting dose of 50–100mg Thorazine intramuscularly; 100mg is then given orally each hour until the patient is asleep. With this dosage schedule, he has routinely been kept asleep for 48 to 72 hours, with breaks for the latrine, some fluids, and perhaps one meal a day. Most mental health personnel have found this routine very effective in stabilizing acute problems. It is very safe and the patient can be easily aroused if necessary.

There has been little use of such modalities as hypnosis and sodium amytal narcosynthesis. Perhaps this has been because of the rarity of actual combat related conditions and because of the presence of the multipurpose phenothiazines.

Psychotherapy has been quite limited, with the use of group, short-term and behavioral techniques being foremost.

Discussion

The primary goal of Army mental health services is to preserve the fighting strength. It is expected that soldiers in a combat zone will experience varying degrees of discomfort. This is a sacrifice which society expects them to make, and mental health personnel are guardians of this painful reality. Individual symptoms are minimized, and the emphasis is placed on keeping the individual a functioning member of his unit. The small group ties are powerful preventers and healers of the symptoms which are often given psychiatric labels. Once an individual is removed from the group, however, the symptoms tend to become fixated, since he has not only lost the support of the group but also has to justify his leaving it.

To best accomplish their goal, Army mental health personnel have to go forward with the troops, to treat problems where and when they arise. They also have to cultivate the attitude of expectancy, *i.e.*, the soldier will be able to return to duty, no matter how bad he looks. These principles have been described in greater detail by Glass (1970).

Mental health personnel have been criticized for their involvement in Vietnam. It has been implied that to maintain the fighting strength in such a controversial war, by sending reluctant, nervous soldiers back to duty and possible harm, is both inhumane and unethical. As has been stated, the military mental health worker is first and foremost a guardian of reality. And the reality is that we are fighting in Vietnam, and someone has to carry a gun there, even though very few men actually choose to do so. If one soldier is relieved of this duty, another will have to replace him. And the soldier replaced by another will have to live a long time with the realization that he was so "sick," so weak, that someone else had to take over for him when the chips were really down.

There has also been criticism of the technique of bringing the entire unit into the problems of the individual. In civilian life this is done in family therapy, and no one feels then that the rights of the individual or the family are violated. To a soldier, his unit is his family, and in

combat his ties to his unit are often stronger than his ties to his actual family ever have been or ever will be.

Military mental health personnel in Vietnam have been well performing the task that society has asked them to perform.

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For further reference the existence of the *USARV (United States Army Vietnam) Medical Bulletin* should be noted. This professional journal has been published bimonthly since January 1966, as the medium for exchange of medical information in the combat zone. In almost every issue there is some grass-roots material on mental health in Vietnam. It is distributed to most medical school libraries, to major military libraries, and to the military medical departments of most free world countries. A number of individual issues have become collectors' items.

The Military and the Civilian Psychiatrist—United States and Swiss

Why should psychiatrists concern themselves with the military—with being in some sense soldiers themselves? Why can't America, a large and peace-loving country, avoid committing its psychiatrists to a military life? These questions, in vogue today, recall many group discussions we had in the spring of 1964, when a few of us United States military psychiatrists visited several civilian psychiatric facilities in Switzerland. At the famous Burghoelzi Hospital, we talked with Dr. Manfred Bleuler and his staff. At the Psychological Club in Zurich, where Carl Jung, among others, added so much to psychoanalytic theory, we talked with his "successors," Drs. Medard Boss and H. K. Fierz and their associates. When all the Swiss psychiatrists kept mentioning that they were in the Swiss Army, we said, "Oh, you mean you're in the Reserve. You're not wearing a uniform."

The answer was, "Neither are you officers wearing uniforms. You are in peaceloving Switzerland. The Swiss military man has his uniform ready at home along with personal equipment and weapons. He knows precisely his duty, his station, his commander. In less than an hour, most of us can be in battle position. How many active duty American soldiers can say this?"

In further conversations, other ideas developed:

(1) Americans, as individuals, do not want to kill anybody. We want to avoid any kind of war. And yet, we do realize our country must be defended against various enemies, who arise from time to time and try to destroy the important things we live for. Perhaps ten per cent of every man's responsibility is that of defending his country and its institutions.

(2) Now, how do we get out of this conflict between the individual responsibility to be a fighter and the individual desire for peace? Each of us seems to project that ten per cent of himself onto the military man. When we see a soldier we can then say, "Now, there's a killer! Not me, but him." When we psychiatrists find ourselves in uniform, we often imagine that we are not military men at all. In spite of all the evidence that we are committed into the Army as strongly as ever we were into university life, we tell ourselves it's all a game. The ten per cent of self which is responsible for direct defense of our country is securely projected onto a set of other people who, we say, have "military minds."

(3) In Switzerland, however, 80 per cent of the men of military age are in the military service. There is no distinction between regulars and reservists. There is nowhere to project that ten per cent. Everyone keeps it within himself. The citizen says, "*I* am a military man; *I* will, if necessary, kill in defense of my country." The Swiss people believe that if this direct military responsibility were not held fast within the heart of every citizen, Switzerland would quickly cease to be a nation. Hitler, desperately needing more direct control of the Alpine passes, once poised his armies to overwhelm Switzerland. But he relented. His staff considered the cost would have been too great. Even today, we were told, Switzerland has the largest army in free Europe.

(4) But what happens eventually to a country which projects military responsibility onto some soldiery, while the rest of the citizens disown any such personal military commitment? Sometimes such an attitude has made the alienated military feel less responsible toward the citizenry. In the Rome of 200 A.D. the urban population preferred to pay a staggering tax rather than to serve on the frontier. Eventually, the city's Practorian Guard auctioned off the Office of Emperor to whomever would pay each soldier the highest bonus. This loss was only "recovered" by a larger Roman army, which established as emperor its own commanding general, Septimus Severus.

It seems to us, then, that the psychiatrists of the most peaceful and democratic country in Europe take their military responsibility the most personally.

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PSYCHIATRY IN COMBAT ZONES*

by

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This paper concerns management of U. S. Army psychiatric services in Vietnam. Comparison is made with Korea and earlier combat.

The general principles of combat psychiatry developed in WW I (Salmon 1927) have never been outmoded though they have been refined whenever the Army in each succeeding conflict really began to practice them. They were first rendered in the current tripartite form by Artiss in 1963. Essentially the principles were these:

1. Expectancy: Management is accomplished in as nearly a duty-like atmosphere as possible. All psychiatric problems arising in combat are labled "combat exhaustion." This label carries a good prognosis and prevents more ominous labels from being applied as self-fulfilling prophecies. (The effect of any diagnostic label upon the expectations of the patient, his peers, command and medical personnel is so strong that the label must be considered a part of treatment rather than a part of evaluation.) Staff, other patients and visitors maintain a clear expectancy that all the afflicted soldiers will return to their normal duty in a very few days. (Most usually after one full day of rest.) The few soldiers who may have to be removed to the rear are given a more definitive diagnosis than mere "combat exhaustion" and moved out unobtrusively.

2. Immediacy: Psychiatric intervention is usually effected within the hour that definite symptoms develop.

3. Proximity: Intervention is effected so close to the area of operations of the member's squad or team that neither he nor his peers lose the sense of belonging responsibly together.

The employment of enlisted mental health specialists made possible more immediate and proximate intervention as well as greater general effectiveness. Even if there had been ten times as many psychiatrists, these specialists would still be indispensible because they could quickly derive from the units information unavailable to officers, and they could develop a usefully different sort of rapport with soldiers. When enlisted specialists were the initial psychiatric interveners or counselors (not mere history-takers) the patient's duty time lost was less than when psychiatrists were the initial interveners. (See the Articles by Gerald Motis in USARV Med. Bull., 1967, 1968)

The Specialists were supervised closely by a fully trained psychiatrist

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and in Vietnam also by a social work officer. For division troops both of these officers were members of their combat division. For non-divisional troops these officers were assigned to a forward hospital.

The Profession's Amnesia

Between wars military medicine tends to forget how to apply the principles of combat psychiatry. Even if a single young practicing psychiatrist did remember them, the commitment of his medical companions to hospital and clinic practice would tend to revert him also to that sort of management.

In the urgent rush to control pain and psychiatric or surgical emergencies there is a human tendency to neglect preventive measures. The following history will show that the theater medical command's direction has been necessary to institute preventive practices and to overcome the professional amnesia between wars.

Korea

For the first three months of the Korean conflict four of the five U. S. Army divisions contained one or two division psychiatrists but all of these doctors were working as general medical officers - not as psychiatrists. Two hospitals had partly trained psychiatrists but they also worked as general medical officers. Psychiatric casualties at the highest constituted nearly 30% of the evacuees. By September 1950 the 600-bed 361st Station Hospital in Toky was filled with psychiatric casualties, and incoming casualties were channeled immediately to Continental U.S.

Colonel Albert J. Glass arrived in Korea in late September 1950 as the first psychiatric consultant to the U. S. Army Far East. He quickly made sure each Combat Division had a Division Psychiatrist working full time in his specialty and following the principles of combat psychiatry. He then pooled two psychiatrists and some other mental health personnel into a single field hospital near Seoul to back up the Division as well as the non-Divisional support units.

In December 1950 five additional psychiatrists were sent to Korea. These men eventually formed the core of a "KO team" - a multidisciplinary mental health team which could break up to augment any services the theater consultant wished, or it could function intact as second echelon psychiatric service for the whole theater. At the close of fighting in 1953 this KO team was stationed in its own compound independent of any hospital and a few miles north of Seoul. From October 1950 therefore, till the end of the conflict any patient in the far south

needing more than local psychiatric care was evacuated "retrograde" 300 miles closer to the front. The official composition of KO teams varied slightly but typically consisted of three psychiatrists, one neurologist, two social work officers, one psychology officer, and about ten enlisted men. In actual practice there were often twice that number of enlisted men.

After 1950 the psychiatric casualties evacuated from Korea amounted to about 4% of all medical evacuees.

Vietnam

In the fall of 1961 psychiatric staff in the Army Surgeon General's Office, Washington, D.C. considered assigning a high ranking psychiatrist to Vietnam to consult upon the management of psychiatric problems and more particularly upon the medical aspects of human relations problems arising among American advisors and between those advisors and their Vietnamese counterparts. Due to the need for medical administrators, however, it seemed certain that such a consultant would not be allowed to function as a psychiatrist. In the press of trying to accomplish prodigious work in medicine and surgery with a handful of men it always seemed easy enough to bring junior officers fresh from civilian training to do the specialty work. The main problem was to obtain broadly experienced administrators to organize the work flow and to set policies so that a few specialists could accomplish it. The first U. S. Army psychiatrist in Vietnam, a Regular Army major, arrived in October 1962. Except for some urgent command consultation with three helicopter companies he quietly saw a few patients at a Saigon dispensary. Because he could not get orders to travel, he failed in his attempts to act as consultant to doctors and commanders who were handling the behavior problems in country. After four months he advised the Surgeon General that the most important place for a psychiatrist would be at the military advisory group headquarters with orders to travel out to field units. He could then influence personnel and human relations policies at headquarters as well as help groups in the field to prevent or manage problems of deliquency, alcohol accidents, drug abuse, and poor relations with the populace. A second Regular Army psychiatrist was assigned to the field hospital at Nha Trang from June 1963 to March 1964. He was utilized mostly as an administrator and general practitioner. For about a year after this Washington sent only reserve psychiatrists. The medical system in Vietnam at least permitted them to function full time as psychiatrists. (Huffman, 1970).

It had proved rare that any doctor not a psychiatrist experienced in combat could commit himself and his juniors to the three principles of combat psychiatry. The practice of preventive psychiatry was so at variance with the protective care of the sick in hospital based medicine that without strong pressure from medical command most psychiatric patients were either be evacuated or treated at length as individuals in a clinical setting. Accordingly in November 1965 a Senior Board Certified Psychiatrist was made theater consultant.

In general, as each Division went into action in the troop buildup of 1964-65, it took its own psychiatrist with it. In 1965 two KO teams were sent to Vietnam. Each field and evacuation hospital had space for one psychiatrist. Sufficient psychiatrists to fill all spaces were made available to Vietnam, but their actual station was determined on the recommendation of the theater psychiatric consultant. As high as twenty-two Army psychiatrists were utilized in country. The best trained were made division psychiatrists or chiefs of KO teams. Policy was that only a KO team should evacuate an Army psychiatric patient out in Vietnam. The most notable deviation from this policy occurred during the Tet Offensive of February 1968 when an airmobile Division lost 30 psychiatric patients to offshore hospitals that month because they by-passed the temporarily inaccessible division psychiatrist and also by-passed the KO teams. All other Divisions (and ordinarily this one also) evacuated out of the Division's area of operations an average of four psychiatric casualties per month. The KO teams returned half of these to the Division. Thus only two such casualities per month left from the average Division.

The mental hygiene team of a Division consisted of one psychiatrist, one social work officer and eight enlisted social work/psychology specialists. The Airborne and Airmobile Divisions had only five enlisted specialists. From July 1967 to July 1968 each Division's team interviewed from 50 to 250 new patients a month. This omits the patients managed by non-psychiatric personnel who were consulted with or supported by psychiatric personnel.

Considering that the average Division team supported 18,000 troops, the rate of evacuation out of country from Divisions averaged 1.3 per thousand for the year. The psychiatric evacuation rate for all U.S. Army troops in Vietnam was about 2.0/1000/yr. The psychiatric evacuations averaged 2% of the total Army medical evacuations. The monthly psychiatric morbidity ranged from 7.5 to 16/1000/yr. with an average for the whole year of about 13. This morbidity includes only those patients who lost at least 24 hours of duty because of psychiatric evaluation or management.

Vietnam and Korea

Generally in both Korea and Vietnam psychiatric patients were first counseled by an enlisted specialist or general medical officer with the supervisory support of a forward psychiatrist. All patients evacuated by the first echelon psychiatrist went to one of the theater's treatment centers (usually manned by a KO team.) These patients were then evacuated only to Japan, not directly to the U. S. These "fermentation pools" in the evacuation cascade were in themselves a part of the treatment process. They kept evacuation rates low. For instance a hospital of Division psychiatrist might receive pressure from his command to evacuate someone who was merely drinking too much. This pressure would seldom affect the backup treatment center. It was under a different command. Inappropriate evacuations were returned to their original duty.

In Vietnam forward psychiatrists and general medical officers treating psychiatic casualties who showed anxiety and exhaustion found that small doses of chlorpromazine (e.g. 10 mg) had far more than the expected effect in relieving symptoms and enabling the soldier to regain full function. Occasionally men returned to duty while they continued to take low doses of chlorpromazine for a few days. Higher doses of chlorpromazine for one or two days brought a restitutive sleep out of which men were easily aroused for meals and toilet. Drugs other than the major phenothazines were seldom used. Very few amytal interviews or hypnosis sessions were conducted. The same ventilation, reassurance and security effects seemed to be obtainable by putting the patient into the appropriate socially expectant atmosphere and by getting close rapport with him as a human being--avoiding those "magic" drug and hypnosis methods which seemed to set him aside from the average military member. No electroshock therapy was ever used in Vietnam. There were no locked wards nor seclusion rooms. One KO team kept all its patients in normal duty uniforms.

Psychiatrists from Vietnam who visited offshore and Stateside hospitals often found their former patients on locked wards--all patients in convalescent clothes, all staff wearing "whites." At ward conferences patients seemed to have less to say about each other's management than they had had in Vietnam. To the combat psychiatry consultant Division mental health teams seemed to know the most about psychiatic management. KO treatment teams were next. Hospital personnel in the U.S. seemed to know least. The front always learned quickly from the rear, but the rear could not appear to learn currently from the front lest the prestige of great medical centers be somehow compromised.

The senior colonels who were theater consultants in psychiatry seemed to be the strongest single factor keeping medical personnel and the theater command oriented to the principles of preventive and combat psychiatry. they helped men who had never practiced this kind of psychiatry to realize that immediate, proximate, expectant management in a non-medical atmosphere is here more effective than the best hospital treatment in the distant rear. They put high professional prestige where it was most effective--in the Division mental health teams.

Good personal communication among all mental health psersonnel in all armed services of all allied nations was imperative to the efficiency of the "mega-hospital" which constituted the total medical service in the combat theater. Collaboration with combat units promoted the clinical skills appropriate for the personal "commitment and concurrence therapy" (Bushard 1967) so supportive of persons in combat. Communication was promoted by in-country mental health personnel who took turns as traveling consultants, by special training conferences (local or international) by two-way reports among the echelons of mental health care and by a medical journal for the theater of operations.

The USARV Medical Bulletin

Throughout the war the theater psychiatric consultant acted as editor-inichief of the USARV Medical Bulletin. Publishing many articles by mental health personnel of various ranks and grades, this journal promoted a dialectical development of ideas and improvisations among the men and women

who directly served the patients and the combat units. Several important papers on military mental health were reprinted, including General Westmorland's Mental Health--an Aspect of Command

Views contrary to general policy were published along with all the others. The reader must be especially cautioned that psychiatrists in Vietnam sometimes wrote as if combat exhaustion (or combat fatigue) were a separate psychiatric entity reportable on a par with character disorders, psychoses, etc. Overall Army medical policy in the last three wars, however, has called all combat psychiatric casualties combat exhaustion initially no matter how much they looked like severe schizophrenia or mild character disorders. This combat "diagnosis" with its automatic expectancy of shortlived disability decreased the morbidity in WWII and Korea. Since any reaction keeping a soldier off duty for more than a few days is by definition something other than combat exhaustion, statistics should never show out-of-country evacuation for combat exhaustion.

Some psychiatrists in Vietnam, perhaps more than in other wars, easily maintained back-to-duty expectancy even when initially diagnosing character disorder, transient psychosis, etc. These psychiatirsts showed no personal need to explain the symptoms on the basis of nerve lesion or old habituational which crippled the soldier emotionally for guard duty, air transportation, patrolling of other current work. They considered that a member's emotional ability to perform was lagely determined at the present day interface between the individual and his mission-oriented primary group (his squad, platoon or possibly company.) Nevertheless, since the diagnostic label affected command and peers as well as medical professionals, the consultants advised the use of combat exhaustion as initial diagnosis.

Summary

In spite of the professional literature, the principles of preventive and quickly restorative psychiatric management in combat were not naturally learned in any training outside the combat theater, They were typically forgotten in peace time and were not practiced in war, until the theater medical command directed it. This was accomplished through the theater surgeon's psychiatric consultant who taught and consulted face to face with mental health personnel in the field. The effect was a steep reduction in psychiatric disability.

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CHARACTERISTICS OF PREVENTIVE PSYCHIATRY FACILITIES

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Washington

Of the 62 federal, state and private community mental health facilities I consulted with from 1968 to 1972 I found only eleven centers which prevented morbidity by dedicating their efforts to the community as a whole. Most of the new mental health centers did not attempt any strong preventive work. They did little beside traditional hospital and outpatient service. They merely got a better building, more money, and did twice as much office treatment as before with twice the staff.

1. Some characteristics of this non-preventive work were:

a. Staff usually worked directly for a university, the state, or a private corporation. It was not hired and fired by a body of local citizens whose children were growing up in the community served. The professional staff members often lived in a different community from the one which contained the majority of the problems. Staff members tended to jockey for position in an academic hierarchy rather than to concern themselves immediately with the problems of a community where they themselves did not benefit from improved public schools, police, recreation, citizen cooperation, etc.

b. There was a long waiting list for the full treatment which the center asserted was its best. The patients and their referring institutions, discouraged by the wait, sought other means of allaying anxiety. Some centers, for instance, could work with three new juvenile drug abusers a week; but the courts they served had to handle somehow 30 a week.

c. As these centers delivered the best of care to whomever the staff took on as a patient, the rest of the community was neglected. The staff felt no responsibility for this neglect. "We haven't taken them on as patients." The staff held that it was giving good treatment to 10% of those who needed it, but failed to add that by so doing it was denying treatment to 90%. The fortunate 10% usually included the cleverest and most powerful families in the community. Since those families had no need to complain, the community's major power never questioned the existing system of psychiatric work.

d. Staff members were often permitted to do private practice on the side, thus committing themselves to other than preventive work. Most private practice thrives on morbidity, not on its prevention. It is financed by individual patients, not by organizations, nor by extended families which so often have to be involved in preventive work. The center was frequently used as a clearing house to refer out individuals for costly private therapy. Very few centers, once well established, ever tried to find new methods or to convince their communities to manage differently the delinquent or the emotionally disturbed.

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e. Adult inpatient care was one of the first services set up. "We must relieve the community of the individuals who cause it anxiety. Wards and jails come first, probation services and outpatient clinics second. Organizational consultation and preventive work come last." The preventively oriented neighbors, bartenders, churches or even fortune tellers could help. But they seldom did it as long as that beautiful ward was gaping open to receive the "patient."

f. The really hard cases were sent off to the state hospitals as if those hospitals had the most expert personnel and the best means to get the patient to function back here in his natural community. Yet the bright psychiatrists in local hospitals and clinics maintained that they themselves were more expert than the state hospital doctors--a strange contradiction, unless perhaps these local doctors were mostly concerned with prestigious individuals and interesting symptoms rather than with community needs or the prevention of problems.

g. Highest prestige was accorded the doctor who treated a single patient in the isolation of an office for a long time. Group therapy with its greater complexity of dynamics and with the requirement that the leader perceive alertly a mosaic of fast interactions, was relegated to a doctor with less prestige. The least trained staff had to perform most of the community organization work, the consultation and the visits to homes, jails, schools, courts, companies, and shops.

h. The doctors shied away from community and institutional staff meetings or confrontations with the mayor or sheriff. Doctors preferred to remain in their own clinic-like territory where they were supreme experts. They liked to face only those who were in a one-down position. Some doctors even wore white coats, perhaps to distinguish them from other people.

i. In spite of many protests and promises, centers which did treatment instead of prevention when understaffed, did treatment instead of preventive work when they became fully staffed.

j. Hospital based psychiatrists and other hospital doctors seldom supported extensive preventive work or mental health consultation in the community. A pneumonectomy brought praise to hospital workers. Advising people to stop smoking brought only irritation. Most of the support for prevention, then, came directly from the citizens or from community agencies--courts, legislators, business and professional associations...

2. The true mental health psychiatrists held to most of the following views and and practices:

a. Prevention was the primary concern.

b.. Some individual evaluations, treatments and some group therapy had to be done just as the floor had to be cleaned; but none of these activities was the primary work.

c. The mental health center maintained a public health view--not so much an epidemiological view as a social anthropological one, working with group histories and fashions of behavior. One staff spoke of "clinical anthropology".

d. "Help the individual to develop his potential," was not considered a principle of preventive psychiatry. Rather: "The individual's potential depends on the group he is a member of." One thesis was this:

> An individual of Western culture does not have one chance in a million of arriving spontaneously at the Eskimo's linguistic and social concept of "possession". But a Western child adopted into an Eskimo group conceives it in one month. Similarly, an individual with a certain role expected of him would have difficulty in even planning to change that role. But if suddenly his peer group makes different imputations and expectations toward him as a member, then he has difficulty in <u>not</u> changing.

e. Most important, the staff used the existing community resources--starting with those agencies already well developed and then moving on to discover underdeveloped potential in the community at large. Even when new, such a staff did not act as if it had exclusive knowledge of the correct way to improve human relations and mental health. The preventive psychiatrists asked themselves:

> "Is the time ripe for an enthusiastic group to form around the alcohol problem, retarded children, accident prevention, continuing education, delinquency...? How many housewives have experience in psychology, social work, counseling, recreation? Can wives work in a community guidance program and go to visit child abusers at home, letting the mother talk or cry to them?"

f. The most effective chiefs of mental health units worked most closely with the judges, clergy, Bar Association, Medical Society, sheriff, news editor, TV stations, legislators, school board. He and his associates were so close to the community citizens that these influential offices <u>had</u> to pay attention.

g. The most effective chiefs spent the least time in their offices. The office was mostly a place to make telephone transactions and to do some writing.

h. School, probation, industrial and church groups felt more responsible for mental health when their secretaries typed mental health write-ups. Groups were especially eager if their problem had been handled by conference in their own institution rather than in a clinic office. The problem always looked a lot different in home, school or jail than it did in a doctor's office.

i. The clever chief taught his non-traditional professionals and then learned from them. He always learned more than he could possibly teach.

j. He never selected these colleagues because of their schooling. Schools did not teach them how to work with a group psyche,[1] nor how to think and live as a member of the lower class. Neither did schools teach these things to psychiatrists.

k. While it might staff inpatient wards as a sop for temporary political pressure, the preventive center tried to establish the inpatient services only after those which managed problems in normal community life. Otherwise the center had little control over input and output of patients. First priority went to direct consultation and service to homes, camps, jails, hospitals, industries, and to agencies which got patients into jobs, training, or healthful social groups.

3. The mental health attitude (if not always its practice) can be contrasted thus with the medical diagnosis-treatment attitude:

Mental Health Model	Medical Model
a. The symptom is always a communication from the patient as a person.	a. The symptom is a part of some trouble inside the patient's mind or body.
b. The patient himself is always a communication from some group--family, shop, school, gang...	b. The patient and his symptom would be the same regardless of the social background upon which they appeared.
c. To understand a problem ask: "Why did <u>this</u> patient come to <u>this</u> agency with <u>this</u> complaint from <u>this</u> family or shop at <u>this</u> time?" Possible answers may be:	c. Disease is a thing inside the patient. Its occurrence is fortuitous.
"This <u>patient</u> looks more persuasive than any other member today. He has more justification for the complaint. Or he is more persuasive. He had it before. He has other things going for him such as age, race, rank, sex, which make it hard to refuse him."	
"We don't want any snoopy industrial inspectors or police. We don't want our clergyman or politician because they don't do anything for this sort of problem. So we are sending the complaint to the <u>medical</u> agency."	
"This particular <u>complaint</u> is more likely to get a response from the establishment. Other	

Mental Health Model	Medical Model
members had more painful complaints, but those weren't in style, so nobody even thought to present them."	
"We are about to begin an irritating work program in this company."	
"We presented the patient at this time because we want to show that our new boss is hard to live with."	
d. After we see the way the group of family or peers programs the patient's thought and behavior, we can help affirm his personal value as a separate individual. Otherwise we only maintain an illusion of individuality, and the group sets the patient up again for the same sort of problem.	d. We assume from the first that the patient has by his own choices gotten himself into this problem. We are paid to work with an individual; therefore the sick individual exists.
e. We explore intensely the assets of community, company, family and member in order to get this member and his group to function better now and in the future.	e. We explore intensely the individual's past history. Skipping behind the present bind he is in, we study the historical factors which make present behavior probable. We try to remove his liabilities one by one.
f. Responsibility for a child or adult patient lies with family, school, company or peer group. After that, it lies with the community.	f. I am responsible for my patient. I hold the patient responsible for his behavior. To hold a father (or employer) responsible is to encourage the patient to behave so as to bring the community down on his father...
g. We evacuate the patient to the working community. Move him toward duty and responsibility in a natural group. Allow very little regression; for regression is the disease. It is not merely a manifestation of the disease, nor does it help throw off the disease--as in some surgical or medical illnesses.	g. We evacuate him to bigger and better facilities which look more and more artificial and where the patient feels more irresponsible. We advise lots of convalescent vacations. Everyone has a human right to be sick.
h. To effect a cure we get the patient a useful membership in a natural working and living group, not a hospital ward nor a therapy group. Then we make sure the group has a task--working upon a problem external to the group and binding the members together. Individual development usually proceeds on-the-job without much medical help.	h. We isolate the patient from his group, put him in an environment controlled by the doctor, use the doctor-patient relationship to change his body or mind. When he is well again, we send him back to work.

Mental Health Model	Medical Model
i. We rehabilitate the patient by getting him a respectable role, not just a job.	i. The patient needs a job, not a role. Jobs enslave the individual only for part of the day. The rest of the time he is free. A role binds him always to a group. It even creates some aspects of his personality.
j. If someone in the community commits suicide, it is partly the fault of the preventive psychiatrist. It makes no difference whether the patient ever came to the psychiatrist.	j. "I feel very bad if a patient I am treating commits suicide. But if he's not my patient, I could care less."
k. His staff and community can easily criticize the director of a good center. He is ready to change his personal identities and orientation as the months go by.	k. The chief of the mental health center is a god. He took this job because he was a supreme expert. To criticize him is to destroy the center's discipline. He must maintain a single professional identity of he'll become neurotic.
l. With one or two social workers or psychologists one psychiatrist can serve a community of about 40,000. They would necessarily work with 20 or 30 non-traditional professionals (neighborhood workers), for these men and women are closer to the local clients. This is sufficient staff if the various community agencies work with each other instead of trying to outshine each other or to convert each to the other's professional "religion."	l. The best staff would consist entirely of board certified psychiatrists. "Non-traditional professionals" are only poor expedients. Competing community agencies assure improvement and progress for the public good.
m. For preventive psychiatry any good handbook such as Caplan's[2] on community consultation is a more practical guide than the most extensive theories confined to middle class individual treatment.	m. No preventive psychiatry guide fits our particular community. So we revert to traditional individual treatment.

4. Conclusion

Psychiatrists are a community resource just as the water supply is. If a fraction of the community buys up for itself the psychiatric talent

(or the water), the rest of the community will actually pay for it--in suffering if not in dollars. Communities cannot morally tolerate professional irresponsibility for all but a fraction of the community--nor a dedication to purely individual morbidity. On the other hand, most professionals are trained only to care for the individual clients in isolation. They feel that if morbidity decreased, their community would no longer need them. They cannot dedicate themselves full-time to prevention nor to the medical psychology of social organisms. Using the traditional medical model, then, psychiatry cannot long survive. Yet the progressive psychiatrist who advocates preventive psychiatry dares not really deliver it lest he be ostracized by his traditional colleagues.

References:

1. Parrish, Matthew D. : A Group Psyche Model for Teachers of Community Psychiatry, Psychiatry 31: 205-212 Aug 1968

2. Caplan, Gerald : The Theory and Practice of Mental Health Consultation NY, Basic Books 1970


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